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**MANAGEMENT IN PRACTICE: ANALYSING THE IMPACT
OF POLICY CHANGE ON MANAGERS AND DOCTORS IN
GENERAL MEDICAL PRACTICE**

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of the requirements of the
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for the degree of
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Criminology Subject Division

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ABSTRACT

This thesis explores the impact of changes in health policy introduced by Conservative administrations in the period 1987 to 1995 on the definition, management and control of professional work within general medical practice. The research underpinning this work combined secondary analysis, large-scale primary fieldwork and qualitative research with clinicians and managers. The first stage of primary fieldwork was conducted during the period September 1994 to June 1995 and consisted of a postal survey of 750 practices across England and Wales. This was followed up with a second phase of research involving depth interviews with managers and clinicians, delivered in the period July to November 1995. This pluralist methodology sought to connect micro and macro levels of analysis in exploring the relationship between the state, professions and managers in primary care.

The research explores the extent to which a number of professional freedoms have been challenged by policy change including political, economic and technical autonomy and the extent to which this had changed the position and rewards of managers in general practice. Employing a multi-dimensional approach to the analysis of power this thesis suggests that prevailing theories of a decline in professional power, based primarily on economic relations at the macro level cannot account for the complexity of relations found in UK general practice.

Further, studies focusing at the collective level of bargaining between the state and the medical profession in the UK have over-estimated the impact of policy change due to a neglect of study at the micro level. Rather this study has revealed a complex picture of both continuity and change in which general practitioners have lost, retained and in some cases extended their power as a result of policy initiatives. Whilst professional freedoms have remained relatively intact, the impact of policy change on the occupation of Practice Management has been more significant, with prevailing discourses of 'managerialism' creating gendered struggles over the definition and meaning of management in primary care.

This work therefore calls for a multi-dimensional account of social life which can explain the complex interaction of differing sites of power, within which a wide range of power resources are deployed. Further this work would endorse a dynamic concept of power in which 'patterns of interaction' (Bradley 1999) are fluid and changeable rather than fixed and self-sustaining systems. It is argued here that constraints on social action are created by the history of past agency, embedded in institutions and social practices that both shape, and are shaped by the agency of individuals.

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I would also like to thank Paul Verrill for his unstinting support and sufferance of many lonely weekends.

AUTHORS DECLARATION

I confirm that this work has not been submitted for any other award and that it is the work of the candidate alone. Joint publications produced under the related project 872/R037 are included in the appendices to this thesis and chapter six draws, in part, upon analysis presented in these joint publications.

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INTRODUCTION

‘Public services have been subjected to some considerable and unprecedented pressures over the last decade or so. Among other things, there has been budget cutting and reductions in establishment levels as well as changes in organisation and management control methods’ (Ackroyd and Soothill 1994: p13).

This thesis examines the impact of changes in ‘organisation and management control methods’ of ‘professional’ work, tracing back the origins of the concept of professional work and examining the relevance of prevailing theories of a decline in professional power to the context of changes in general medical practice in the mid 1990s.

The primary research underpinning this work was undertaken during the period 1994 to 1995 and aimed to explore the impact of major changes in health policy introduced by the Conservative administration from 1987 up to and including the active field period (Secretaries of State for Social Services 1987, Department of Health 1989, 1991, 1992).

Analysts of health policy over this period (Ham 1997, Pollitt 1993, Clarke and Newman 1993) identify a significant shift in the approach of the State to professional workers with the introduction of a ‘managerialist’ approach to health care, in which resources are directed to ‘strategic’ health goals and practitioners are held more directly accountable for the allocation of resources and achievement of specified outcomes.

The reforms of the late 1980s and early 1990s presented significant challenges to general practice. An increased focus on preventative primary care as a means of reducing spend on acute services led to an ever-widening scope and remit,

increasing organisational complexity and escalating pressure to manage resources effectively.

The introduction of an internal market in health care (Department of Health 1989) led to a dual role for some GPs as both purchasers and providers of care: the former requiring the GP fundholder to act in the best interests of the practice population, the latter in the best interests of the individual patient. GP fundholding introduced the first ever cash-limited budget for GP referrals and, along with a shift in core practice funding towards performance related rather than per capita payments, required GPs to become more accountable for resources and more strategic in their activities.

I. Research Objectives

These changes presented a significant challenge to the managerial function in general practice. Adopting an inductive approach this study aimed to explore the resulting impact on the organisation and control of clinical work and subsequent implications for managers and clinicians working within general medical practice:

- Had state policy succeeded in challenging 'professional' autonomy and introducing a more strategic approach to the management of health care resources?
- How had managers and clinicians responded to the external policy context?
- What were the implications for the roles and rewards of managers in general practice?

The objectives of the study embraced both micro and macro levels of analysis in:

- Assessing the external dynamics brought to bear on general practitioners via the introduction of policy change
- Analysing the occupation of practice management across England in terms of the profile and rewards of practice managers

- Exploring the roles of managers and clinicians within individual practices.

II. The approach

Building on linked research into human resource management in primary care, the profile and rewards of practice managers were identified via a postal survey of 477 practices across England.

This quantitative study revealed a number of important issues including:

- Entry of male managers to practice management occupations coinciding with the introduction of the new GP contract and fund-holding scheme
- Marked and consistent inequality in the rewards of male and female managers
- The apparent limited authority of managers to make independent decisions regarding the management of practice staff.

The quantitative study therefore suggested that important changes were taking place in the profile and rewards of managers yet this, on the face of it, did not appear to translate into enhanced authority for managers in decision-making.

A more qualitative approach was required to explore and further explain the trends identified by the quantitative survey, involving a total of sixty depth interviews with managers and clinicians in practices across England. Interviews investigated perceptions of the identity and role of managers in general practice from the perspectives of clinicians and managers themselves.

The benefits of combining quantitative and qualitative methodologies is evidenced by this study which has confirmed the strength of policy challenges at the collective level of the profession yet has questioned their impact on the daily practice of clinicians. Change has brought with it implications for the gendering of managerial occupations within primary care whilst having limited impact on existing

relationships between 'managerial' and 'professional' roles and authority at the micro level.

III. Relationship with existing work

This work has sought to build upon the disciplines of gender, organisations, managerial and policy studies to provide the 'full picture' of what was happening to the status and authority of clinicians and managers in general practice in the period under study.

The breadth of the study has in some cases necessitated sacrifices in the depth of literature review. Many strands and avenues of analysis could have been further developed, however it is argued that the strength of this work lies in its ability to draw together the insights of a range of disciplines thus avoiding the 'blind spots' of singular schools. An overwhelming sense of fragmentation has been encountered in this task and it is hoped the resulting thesis may contribute, in some small way, to a more holistic understanding of power relations.

A number of important gaps were identified in existing research of relevance to this study. Whilst policy analysts give detailed accounts of the process and content of policy making, the impact of policy on grass roots or 'micro practice' is largely neglected. Whilst it can be argued, for example, that the political thrust of the fundholding initiative was to increase accountability and encourage a more strategic approach to resource management as part of an assault on professional autonomy (Klein 1995), depth interviews would suggest limited impact on the outlook or behaviours of clinicians.

Feminist analyses have addressed the position and progress of women in professional (Witz, 1990) and managerial occupations (McDowell, 1997) but have not addressed the intersection of the management of professional workers. On the other hand, studies of the 'management of professional workers' (Freidson 1970,

1973, 1986, Mckinlay and Arches 1985) have typically been ‘gender blind’ (Halford et al 1997).

The majority of work across all disciplines has a tendency to focus on large-scale organisations in the public and private sector with a general neglect of small and medium sized organisations in general (Rainnie 1989) and ‘professional’ sole trader or partnership organisations in particular. One of the most important defining factors in terms of the structural relationship between GPs and the NHS at the time of this study is that the majority are contracted to deliver services on an ‘independent contractor’ basis. This means they are *self-employed practitioners* within small partnership or sole-trader business structures. Not only do the majority of GPs own the businesses they operate in, they also provide a large proportion of the services delivered. Thus this study is distinct in focusing on small organisations where self-employed practitioners are both the owners and ‘shop-floor’ workers. Given the centrality of this structure in the delivery of health care, increased study and understanding of the dynamics within these types of organisation is required.

This thesis therefore makes an original contribution to our understanding of power and authority by bringing together the study of gender, management and professional work within a neglected organisational form. The study provides a robust quantitative measure of the profile and rewards of practice managers and a qualitative measure of the early impact of ‘managerialist’ strategies on the micro power relations in general practice: baselines against which future shifts in the orientation and authority of professional workers and status and rewards of managers can be compared.

V. Structure of the Thesis

This work commences with an overview of general practice, briefly covering the development of the profession and its relationship with the state in order to place recent policy change within its wider context.

Chapter two introduces the Practice Manager role, outlining the roots of the occupation, its profile, size and changing position as perceived by occupational associations and practitioner literature.

Key bodies of existing literature are then reviewed. Literature contributing to the study of 'the professions' is reviewed in chapter three, where the development of the concept of 'professional work' is explored. This chapter reviews the changing focus in the study of professional workers from early attempts to define and categorise them (Carr-Saunders and Wilson 1933, Greenwood 1957, Etzioni 1964) to analyses that identified the process of professionalization as a means of achieving 'occupational control' (Freidson 1970, 1973, 1986, Larson 1977). The emphasis of later analyses has been on a perceived decline in professional powers brought about by the interests of capital to control the labour process (McKinlay and Arches 1985) and/or State attempts to control public spending (Ham 1997, Pollitt 1993, Clarke and Newman 1993).

The importance of gender as a central factor in the definition and rewards of managerial careers emerged very early in the process of fieldwork and the literature addressing women's position in the labour market is evaluated in chapter four. A wide range of theories are reviewed from the 'Domestic Labour Debate' (Secombe 1974) through to Dual Systems Theories (Walby 1986, 1990, 1997) and post-structuralist and post-modernist analyses.

The philosophical underpinnings of this work are presented in chapter five which reviews the research methods adopted, the assumptions underpinning them and the reflective experience of undertaking the research.

This leads into a detailed analysis of the primary data collected. Chapter six focuses on the role of management within the practice, as perceived by managers and GPs themselves. Chapter seven considers the extent of management involvement in the control and organisation of clinical work, assessing the validity of theories of a

decline in professional power with reference to the experiences of managers and GPs at the micro level. Chapter eight explores the 'gendering' of the practice management role and the resulting impact on the status and position of female managers in general practice.

Chapter nine and the thesis conclusions draw the above analyses together in considering the contribution of existing theories to an understanding of the position of managers in general practice. It is argued that a multi dimensional concept of power is required in order to explain the complex dynamics identified in this work.

CHAPTER ONE

GENERAL PRACTICE IN CONTEXT

INTRODUCTION

General medical practice is an under-studied industrial sector and organisational form; this chapter provides an introduction to the sector such that research findings can be viewed within the wider context.

The chapter commences with an outline of the characteristics of general practice as it exists today. An overview of the sector's historical development is also provided including a review of major NHS reforms up to the period of active field study (1994 to 1995)¹.

1.1 General Practice Today

At the time of writing the head of the NHS in England is the Secretary of State for Health, based within the Department of Health. From the year 2000 the Government devolved some aspects of health care to the Scottish Parliament and the Welsh Assembly and it is expected that the Northern Ireland Assembly will eventually take over at least some aspects of health care in the future.

General practitioners (GPs) are often referred to as the 'front line' of the health service, providing a 'gateway' to specialist health care provided in the secondary and tertiary (referrals within secondary care) sector. With the exception of emergency self-referral, a patient cannot normally consult a doctor in secondary care without prior referral by a GP. It is estimated that approximately 97% of the UK population is registered with a GP with an average length of registration being twelve years.

¹ Key policy changes occurring since the completion of this research are highlighted in the thesis conclusions.

GPs can choose to operate alone or in partnership. The number of GPs practising as single-handed service providers has been gradually falling following the introduction of the 1965 Family Services Charter and subsequent policy changes and incentives which have encouraged the formation of group practices of increasing size. In 1980 14% of all GPs² in the United Kingdom were single-handed falling to 8.1% in 2002. Over a third of all GPs in the United Kingdom now work in practices of six partners or more, compared with only 12% in 1980. The most recent figures available indicate that there are a total of 10,679 practices in the UK. (RCGP: 20032)

Traditionally a male dominated profession, an increasing number of women are entering general practice. In 2002 37% of all GPs in England and Wales were women, compared with 25% in 1990. This trend is likely to continue, as by 2002 more than 62% of all GP registrars were female (RCGP: 20031)

1.2 Structural Relationships

One of the most important defining factors in terms of the structural relationship between GPs and the NHS is that the vast majority are contracted to deliver services on an 'independent contractor' basis. GPs are self-employed practitioners working within a partnership or sole-trader business structure. The contractual agreement to deliver certain services to the NHS is negotiated at a national level and consists of specific 'terms of service' which apply throughout the UK. The General Practitioner Committee of the British Medical Association negotiates the terms of the contract with the government. As summarised by the Royal College of General Practitioners (RCGP):

'GPs have autonomy to run their practice in their own way, allowing them to provide a more personalised and flexible service. This, however, brings with it the responsibilities of managing staff and maintaining premises and equipment. Health authorities/boards cannot tell GPs how to practice; they can only advise. (Authors emphasis RCGP May 1999:3)

² Figures based on 'unrestricted principals', that is a GP who is contracted to take unsupervised responsibility for any 'type' of patient. A restricted principle is one who is contracted to treat only a specific group of patients or certain types of care e.g. maternity care (RCGP: 20031)

From 1948 to March 2004 the state (in its various administrative forms) contracted with GPs on an individual basis. Patient registration was with an individual practitioner and not the GP 'Practice', confirming the long-standing concept of the individual 'doctor-patient' relationship. Following introduction of the new contract for General Medical Services in 2004 (D.O.H 2004) the contract is now between the Primary Care Trust (freestanding NHS primary care organizations accountable to local Strategic Health Authorities³) and the practice. Patients will also register with the practice rather than individual GPs.

Whilst this is a significant change to contracting arrangements GPs still retain their self-employed status: a status that is identified in this thesis as a key element in the control and management of their labour process and one which distinguishes them from clinicians in acute care, and other professional workers employed in private and public sector organisations. This status results from the historical development of a profession initially divided on the basis of social status as opposed to technical expertise⁴ (Waddington 1984).

1.3 The Development of General Practice

Historical analyses chart the development of a profession split by community and hospital based care with the latter being monopolised by elite physicians and surgeons whom, by virtue of social position gained early control of university based education and training, subsequently imposed as a requirement for career positions in the expanding hospital sector.

³ There are 303 PCTs in England, each charged with planning, securing and improving primary and community health services in their local area. The PCT board is comprised of a majority of lay members, who work closely with the PCT executive representing general practitioners, nurses and other community staff (RCGP 2004).

⁴ Historical analyses (Allsopp 1995, Waddington 1984) commonly identify the development of a tripartite system in early health care headed by the university trained physician, followed by the surgeon as craftsmen and apothecaries considered as tradesmen. The Royal College of Physicians London was established in 1518 and was comprised chiefly of the privileged few who could afford the religious and classical education offered at the universities of Oxford and Cambridge, often followed by the study of medical subjects in European universities. Early divisions were reinforced by subsequent monopoly and control of university based education and training

The 1911 Health Insurance Act was the first major involvement of the state in community based health care involving the transfer of the administration of health care insurance for low paid male workers to new insurance committees upon which GPs had representation. The Act increased the financial security of general practice and fixed the fees received by GPs. Practitioners remained as independent entrepreneurs whilst having the security of a state administered payment system.

Thus the foundations had been laid for the development of a general medical service based within the community operating on an independent contractor basis with payment via a state managed system. Access to this market was via a qualification and registration system self regulated by the occupation's recognised corporate bodies.

This status has been retained in the face of several attempts to undermine it from the inception of the NHS to subsequent reforms. Remarking on the power of a profession to define the boundaries of negotiation Klein observes:

‘On the one hand it is possible to demonstrate convincingly that the NHS exploited its position as a virtual monopoly employer of medical labour to depress the income of doctors. On the other hand, it is possible to show equally convincingly that the medical profession permeated the decision-making machinery of the NHS at every level and achieved an effective right of veto over the policy agenda’ (1995:49).

The principle of professional autonomy was enshrined in the structure of the NHS:

‘As I conceive it, the function of the Ministry of Health is to provide the medical profession with the best and most modern apparatus of medicine, and to enable them freely to use it, in accordance with their training for the benefit of the people of this country. Every doctor must be free to use that apparatus without interference from secular organisations’ (Bevan 1946 in Allsop 1995:30).

In common with many analyses (e.g Moran and Wood, 1993) Rivett characterises the relationship between the state and the medical profession as being a somewhat reluctant 'bargain':

'Bevan accepted key demands from the doctors. For the specialists this was a part-or whole time salary plus merit awards, and the right to treat private patients in NHS hospitals. For GPs it was a system as far removed from a salary as possible; capitation was a defence against the perils of state servitude. Like it or not, the state and the medical profession had become mutually dependent' (1998:129).... GPs fearing that they might be no more than officials in a state service, argued successfully for a contract *for* services rather than a contract *of* service. As a result they remained independent practitioners, self-employed and organising their own professional lives' (1998:80).

Thus with the introduction of a National Health Service the medical profession had become increasingly dependent on the state for access to the means of practising their trade and the rewards they reaped, whilst the state required the cooperation of the profession to deliver their policy aims and to ration health care.

Analysts suggest that the terms and nature of this 'bargain' have been fundamentally challenged by the reforms of the 1990s which have sought to introduce the values of 'managerialism' in a service organised and controlled by professional workers. The form, content and impact of such challenges on the work of managers and clinicians in primary care are the subject of this thesis.

1.4 Reform of the NHS

The 1974 reorganisation of the NHS aimed to increase efficiency via improved planning and coordination, later reforms were to have a more ambitious agenda to introduce 'General Management' to the NHS. The Griffiths report identified a lack of direction, drive speed and responsibility in decision making, famously stating that:

'If Florence Nightingale was carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge' (Griffiths DHSS 1983:12).

The report recommended a small central management board, coupled with General Managers at unit level. Clinicians should become more closely involved in management decisions, having responsibility for allocated budgets and being held accountable for measurable service outcomes. Whilst retaining a focus on cost efficiency and effectiveness, the language of reform shifted to the intrinsic benefit of 'management' by objectives in the pursuit of increased value for money and higher standards of care.

The introduction of 'General Management to the NHS' had left the GP as independent contractor, untouched. Change was to come later to general practice in the form of three white papers: Promoting Better Health (DHSS, 1987) Working for Patients (D.O.H 1989i) and Caring for people (D.O.H 19892), culminating in the introduction of a new contract for general practitioners in 1990 (D.O.H 1989 3).

1.4.1 Promoting Better Health and the 1990 Contract

A Green Paper 'Primary Health Care - an agenda for discussion' was published in April 1986 (Secretary of State for Social Services, 1986). Following public consultation, the primary care White Paper 'Promoting Better Health' was published in November 1987 (DHSS, 1987).

The key points in the white paper included:

- New payments to encourage preventative medicine and greater efficiency
- Clearer priorities for family practitioner services
- Cash limits on funds for reimbursement of ancillary staff and premises costs, but an extension of the scheme
- The privatisation of the General Practice Finance Corporation set up to help finance the improvement of practice premises
- Incentives for inner city practice
- Nurses to be given limited powers to prescribe
- Pharmacists to be given financial incentives to widen their services

Describing the aims of the White Paper in 1989, the Secretary of State for Health Kenneth Clarke pointed to a need to increase the accountability of GPs to their local populations via increased choice in supplier and the simplification of complaints procedures:

‘In the first place we want to make it much easier for the patient to find the GP that best suits that individual's needs. More information about the services that GPs provide will therefore be made available. The bureaucracy involved in changing doctors will be removed and the patients' complaints procedure simplified. Family practitioner committees will be conducting consumer surveys to ensure that patients' views are being taken into account in the development of health care services’ (Clarke 1989¹: column 800).

An increased emphasis on health promotion and disease prevention was to be achieved, building on earlier incentive payments for immunisations and screening services. The government sought more direct control over the content of services delivered by GPs, largely achieved, as in the earlier Charter, via payment incentives:

‘..important changes are to be made to the GPs' terms of service and remuneration system. The terms of service will in future set out in more specific terms what is expected of a family doctor who is in contract with the National Health Service. Aspects such as health promotion and disease prevention - not previously stated in specific terms - will be made a clear requirement of the GPs contract. Changes to the remuneration system are designed to make general practice more responsive to patient needs and to ensure that the taxpayer gets better value for money’ (Clarke 1989¹:column 800).

Incentives would include payments for additional items of service relating to health promotion and disease prevention and rewards for participating in continuing education.

In contrast to earlier reviews however, the White Paper also proposed a stronger management role for the Family Practitioner Committee (the body responsible for administering General Practitioner contracts) in the allocation of development budgets to encourage greater diversity in the professionals employed within primary health care and to improve the environment in which they operated:

‘Lastly, we are preparing family practitioner committees (FPCs) to play a greater management role in the provision of local services. In particular they will manage service development budgets aimed at improving surgery premises and extending practice teams. The Government believe that GPs working with other health care professionals will provide a better service to patients. FPCs will have service development plans aimed at encouraging greater use of practice nurses, counsellors, chiropractors and other health professionals’ (Clarke 1989 1: Column 800)

Negotiation with General Practitioners on a new contract *for* services commenced in 1988. Opposition to the proposed contract was strong. Responding to a question in the House of Commons in 1989, Kenneth Clarke described the process of consultation as follows:

‘Detailed discussions of the proposed new contract with the general medical services committee, which negotiates for GPs, began in March 1988. Between March 1988 and the publication by the GMSC of its account of the negotiating position and my publication of "A New Contract", my officials held 17 meetings lasting 80 hours with the GMSC. I also held two meetings personally with the negotiators before publication and a third, protracted one afterwards. Subsequent meetings between my officials and the GMSC have taken the total time spent on detailed negotiations past 100 hours.....I believe that the GMSC agrees that the existing contract should be changed and that the changes should be introduced with effect from 1 April 1990. I hope, therefore, that the longest, most protracted, detailed and painstaking discussion of amendments to a contract in which I have ever been involved will soon come to an end’ (Clarke 1989 2: Column 501).

Implementing the proposals of the earlier White Paper (D.O.H 1987) the new contract proposed strengthened roles for newly formed Family Health Service Authorities (previously Family Practitioner Committees) with existing Chief

Administrators having to re-apply for their posts. Membership of the FHSA included a General Manager, Chair and nine non-executive members including four professionals. GP representation was heavily reduced from seven to one.

FHSAs were to have ultimate responsibility for service development with GPs being required for the first time to submit annual reports describing their practice service and plans.

Controversially, FHSAs were also to establish:

‘..rational prescribing policies for their localities, and monitor individual practice prescribing’ (DOH 1989 3).

Any form of external involvement in prescribing activity had always been an issue of significant controversy within the profession, dating from the introduction of ‘limited lists’ in 1985, it being viewed as an intrusion on clinical autonomy.

Further intrusion into the clinical arena was also planned via the requirement on FHSAs to set up Medical Audit Advisory Groups (MAAGs) whose role was to promote and encourage general practitioners to review and monitor clinical practice via medical audit.

Resistance against what was viewed as state ‘interference’ was strong. Rivett notes:

‘It was legal for the Secretary of State to decide the terms on which family doctors worked, but in law there had to be a clear attempt to negotiate alteration. The profession liked the status quo while the government wished for change...The deal was hard for the professions leaders to accept, and it was unusual for the government to lay down so precisely what doctors should do in clinical terms, as in the assessment of those over 75 years of age’ (Rivett 1998:411).

A practising GP writing in 1992 summed up the changes introduced by the new contract as follows:

‘The changes represent a fundamental shift in the relationship between an elected government and an independent profession, which are not a matter of party politics. The aims of the contract were to increase consumer choice, bring health promotion and disease prevention within general medical services, strengthen management and budgetary control, and make remuneration more dependent on performance. The methods used were a mixture of competition, financial control, positive discrimination, financial inducement and legal and prescriptive requirements’ (Hannay 1992:178).

The new contract was finally agreed at a meeting of the Secretary of State and the General Medical Services Committee in May 1989. In spite of the rank and file practitioners’ rejection of the package, it was implemented. An unprecedented move, Rivett compares the negotiation of the 1965 Charter with the introduction of the 1990 contract:

‘GPs had not believed that their contract could be altered without agreement and had been proved wrong. In 1966 the profession’s negotiators held a strong hand. General practice had been deteriorating and was widely regarded as second rate, and morale was low. GPs were leaving practice, Kenneth Robinson, (the Minister) was the son of a GP, and Labour, just re-elected, saw the NHS as its political baby. In 1990 GPs were well motivated, worked in premises provided largely at public expense, had no difficulty in recruiting colleagues, and public attitudes to organised industrial action had changed. GPs faced a strong government determined on customer-orientated reform and their negotiators held but modest hands’ (1998:412).

1.4.2 Working for Patients

Other, more radical changes were to come in the form of the wider Prime Minister’s Review of the NHS, Working for Patients. Published in 1989, the review proposed a market structure within a publicly funded health care service.

Agents within the NHS were to be split into ‘purchasers’ and ‘providers’ of health care. Allocated a budget to buy services, purchasers were charged with assessing the

health needs of their population and purchasing appropriate services from hospital and community units. Provider units were to become 'Self-governing Trusts', competing annually for contracts to retain their viability.

Large public hospitals were therefore given the choice to become Trusts, remaining in public ownership but becoming self-governing, thereby able, for example, to determine local pay scales, terms and conditions.

Districts Health Authorities (DHAs) and FHSAs, previously the managers of services, became purchasers and were free to source services from private as well as public sector provision. Districts retained responsibility for those units remaining under direct management control. In some areas DHAs merged with FHSAs to provide a single commissioning body.

Finally, and crucially for the primary care sector, larger General Practices were to be offered the opportunity to become 'Fundholding', involving the management of a budget to purchase certain services and procedures for their patients from hospitals. Budgets were to be top sliced from District allocations with GPs being charged with spending budgets for the greatest benefit of their practice population. GP Fund holding was seen as a key measure to:

'Help the family doctor improve his service to patients... GPs will be encouraged to compete for patients by offering better services. And it will be easier for patients to choose (and change) their own GP as they wish' (D.O.H 1989 1 para 1.9).

The transformation of the patient into a consumer of health care services, introduced in promoting better health, is therefore reaffirmed in the vision of an internal health care market where customers influence quality via their ability to change supplier, directly or via a proxy purchaser.

Initially open to practices with lists of 11,000 plus patients, the scheme was later extended to practices with 9,000 patients, finally being reduced to 7,000 patients from April 1993.

The scheme initially involved five areas: hospital in-patient care for a limited range of procedures, out patient clinics, diagnostic tests undertaken on an outpatients basis, drugs prescribed by the practice and practice staff. This was substantially extended in 1993 to a broad range of other services including community health services, district nursing and health visiting and chiropody amongst others (Glennerster 1994). The extended version of the scheme was known as 'community fundholding'.

In 1995 the government announced their intention to pilot 'Total Purchasing Schemes', enabling fifty practices to combine with Health Authorities/ Boards to purchase the full range of NHS services. At the time fundholding was abolished in March 1999 nearly 18,250 GPs (more than 50% of GPs in the UK) in more than 5,000 practices controlled over 4,000 separate fundholding budgets (RCGP 1999).

GPs who did not wish to become fundholding had the option of forming GP commissioning groups, acting in an advisory capacity to alert Health Authorities of shortfalls in service provision.

At the same time as GPs were given more influence over the services they purchased for their patients, the FHSA was given a strengthened management function:

'To improve the effectiveness of NHS management, regional, district and family practitioner management bodies will be reduced in size and reformed on business lines, with executive and non-executive directors. The Government believes that, in the interests of patients and staff, the era in which a £26 billion NHS is run by authorities which are neither truly representative nor fully management bodies must be ended. The confusion of roles will be replaced by a clear remit and accountability' (D.O.H 1989 1 para 1.9).

The focus on clinical practice was maintained with medical audit featuring in the seven key measures proposed by the White Paper:

‘To ensure that all concerned with delivering services to the patient make the best use of the resources available to them, quality of service and value for money will be more rigorously audited. Arrangements for what doctors call medical audits will be extended throughout the Health Service, helping to ensure that the best quality of medical care is given to patients’ (D.O.H 1989 1 para 1.9).

The Health of the Nation (DOH 1992) was to extend incursions into the clinical sphere by the setting of targets in areas of ill-health deemed as high priority by the Department of Health, including coronary heart disease and stroke, cancers, mental illness, HIV/Aids and sexual health and accidents.

Following legislation in the 1990 NHS and Community Care Act, the reforms outlined in the white paper were implemented in April 1991. Klein describes political and professional reaction as follows:

‘Political and professional voices spoke with a rare unanimity and with the same intent: to induce terror and apprehension at the thought that the Government was planning to replace the primacy of the patient with the primacy of the pound, forcing doctors to subordinate the search for health to the search for solvency’ (1995:193).

The reforms represented a fundamental shift in philosophy from what Allsop terms:

‘A command and control economy to a managed market within the service’ (1995:172).

Relationships across and within agencies involved in the management and delivery of health care were to undergo radical change. In theory, a market approach would be driven by relationships at the local level, between purchasers and providers of services, with vertical lines of authority to the National Health Service Management Executive becoming less significant.

Reform of the health service mirrored that occurring across the wider public sector, with compulsive competitive tendering in local government and self-governing schools in the education sector. In defining relationships in a reformed public sector, the Treasury stated:

‘..public services will increasingly move to a culture where relationships are contractual rather than bureaucratic’ (HM Treasury 1991:2).

The best standards of service would be achieved by:

- Making managers accountable for performance within a clear framework of objectives and resources
- Distinguishing the roles of policy formulation and service delivery
- Introducing wherever feasible, contracts and service level agreements which define standards of performance and responsibility for meeting them.

(HM Treasury 1991:2)

Shifting the location of care from long-term institutional care in hospital and residential settings to the community (DOH 1989:2) was to form a further key ingredient in the reforms of the 1990s, increasing workloads and raising the profile of general practice.

1.5 The Impact of Reform on General Practice

The reforms of the early 1990s therefore presented significant challenges to general practice. The purchasing role accorded to general practitioners via the fundholding scheme was a complete and radical break from their previous status. Previously at the mercy of hospital consultants with respect to waiting times and service standards, GPs had now been placed in the driving seat, with the scope of the budgets they controlled increasing over the lifetime of the scheme (Salter 1998).

This could potentially change not only the nature of the relationship between health care professionals, but also that between doctor and patient.

Much of the opposition to the fundholding scheme stemmed from the inherent conflict perceived in the dual roles of purchaser and practitioner. The former required the GP to act in the best interests of the practice population, the latter in the best interests of the individual patient.

With the introduction of fundholding the government had introduced cash limited budgets for GP referrals, a concept which had never previously been applied with respect to GP activity. Never before had GPs been required to explicitly take responsibility for the financial implications of referrals made to community and acute services.

Alongside financial accountability came the need to 'think strategically' about health care provision. The requirement to produce practice plans, undertake health needs assessment and increase the scope of services provided under the auspices of primary rather than secondary care, placed significant pressure on the management expertise of professionals whose training had focused on analysing and meeting the needs of individual patients.

At the same time as new responsibilities and authorities were being introduced to GPs, increased management surveillance and control were being imposed. The extended remit of the FHSA introduced by the White paper can be viewed as a marked departure from previous structures, with the emphasis being on a 'general management' function including the appraisal of health needs and a requirement upon GPs to submit and justify business development plans.

An increase in demand for GP services would also be the inevitable and intended consequence of the shift from secondary and residential care to care within the community. This increasing focus on primary care as a means to limiting access to expensive forms of acute/residential care and reducing ill health by active health promotion and surveillance was to escalate over the decade culminating in calls for a 'Primary care led NHS' (Dorrell 1996).

The increased scope of services offered by primary care was to be built upon the foundations of the 'primary health care team', a team that had been expanding since the 1965 Charter introduced 70% reimbursement of staff costs. Health promotion and surveillance targets, among other developments, required an increase in both administrative and clinical staff.

The extension of fundholding to community services served to further increase the range of professionals engaged in primary care settings. A significant move from the solo practitioner operating from domestic premises, the primary care team of the 1990s is described by the Royal College of general Practitioners as:

'Consisting of general practitioners, practice nurses, community nurses, health visitors, practice managers and administrative staff. It may also be appropriate for other personnel - for example fund managers, midwives, counsellors and psychiatric nurses - to be members of the team. The College advocates the use of a wide range of professionals where appropriate such as clinical psychologists, physiotherapists, occupational therapists and dieticians, in order to provide a greater range of services to patients' (RCGP 1998).

The above factors led to a stark and obvious requirement for GPs to review and address the way in which they managed both human and financial resources within the practice. External pressures would be brought immediately to bear via the requirement to establish formal contacts with suppliers under the fundholding scheme. Indeed access to the scheme was dependent on the demonstration of

adequate management resources and information communication technology infrastructures. Significant financial assistance and incentives were available to early fundholders in order to tempt practices into the scheme.

How would these changes effect existing management arrangements within the practice? This is the key question to be addressed by the thesis in respect of the position of general practice in the mid 1990s.

SUMMARY

In mapping the development of general practice from the early tripartite system through to the establishment and subsequent reforms of the National Health Service, this chapter has highlighted the agency of a profession, albeit for the most part comprised of competing factions, to shape and control position and rewards within the labour market. Drawing on the fields of historical analysis and social policy, this overview has demonstrated the ability of an occupational group to lobby and shape policy and legislative change.

Viewed as a significant break from previous restructuring and a challenge to the authority of the medical profession, analysis of the policy changes introduced by the Thatcher government have emphasized the incursion on medical autonomy and the introduction of 'managerialism' to health care. Later chapters will address the extent of 'real change' as measured at the micro level by examining the perceptions, roles and relationships between managers and clinicians in practices across England. Firstly, however, the origins of the practice management role will be reviewed.

CHAPTER TWO

THE PRACTICE MANAGER ROLE

INTRODUCTION

Practice management is identified as an occupation in the throws of significant change. This chapter outlines the development and growth of the role and associated occupational bodies to provide the context for later analysis.

2.1 Early Practice Management

The occupation of practice management largely developed after the introduction of the Charter for the Family Doctor Service (GMS 1965) which encouraged the growth of partnerships in purpose built premises. The service provided by GPs expanded along with the numbers of staff they employed. The level of organisation required correspondingly increased. Early practice managers were mainly promoted from receptionist positions within the practice. Huntington (1992) likens their role to that of a 'housewife':

'Many early practice managers, including 'the girls' (as ancillary staff were and are still called), like housewives, took on all the domestic chores, while hubby got on with the real (clinical) work and brought home the bacon.' (1992:19).

Historical analyses indicate that the General Practitioner's spouse was the forerunner of today's Practice Manager, providing receptionist and administrative support to her husband with the surgery often being based within the family home. Indeed as recently as the early 1990s, spouses engaged in the capacity of Practice Manager were not reimbursed by the FHSA. Historical data is not available on the gender of practice managers, however research undertaken for this thesis would indicate that the majority were female (see chapter six).

'The NHS inherited practices which were often within the doctor's own home...for help the doctor looked to his wife, who acted as an unpaid

receptionist. General practice had a domestic focus with the surgery in the doctors own home' (Loudon et al 1998:47).

Adkins (1995) notes a similar appropriation of labour in the hotel and catering sector where private companies frequently engage married couples in the running of premises, with payment commonly made to the male partner only.

2.2 Management in a Developing Sector

Huntington suggests that during the 1980s women, mainly from retail and commerce were attracted into practice management and challenged the 'housewife' image. The 1990 contract (D.O.H. 1989 3) and fund holding status have acted as a catalyst, enforcing a review of the nature of the management task (1992:19). Similarly Macmillan and Pringle argue:

'Practice managers are something of *a new breed*. They are evolving into serious professionals at breakneck speed with, in many cases, considerable autonomy in running practices - practices which have turnovers similar to small or medium sized business. But some practices already had 'practice managers' before the new contract. The new style business manager, however, is really a phenomenon of the past two years or so. Before that many people with the title practice manager were in fact practice administrators. These were often senior receptionists who had worked their way up through the ranks.....this is not to say that *old style* practice managers will be sent packing. Those who can adapt and take advantage of the increased training opportunities now available are just as likely to succeed as the new whizz kids from outside.' (Macmillan & Pringle 1993:39-44, *author's emphasis*)

The increase in administrative and managerial staff employed within practices is demonstrated by available workforce statistics. There are a number of difficulties in the interpretation of available figures given shifting definitions of roles over time. As table 2.1 indicates, figures for 1992 refer to Management and Administrative staff, whilst 1994 figures relate to those staff titled 'Practice Manager', and 1997 figures refer to both 'Practice Manager' and Fund Managers'.

In spite of definitional issues it is clear that the sector saw significant growth in the numbers of administrative/managerial staff in the period 1992 to 1997, being in the region of 35%.

Table 2-1: Trend in numbers (WTE) of selected practice staff, attached professionals and all practice staff in England & Wales, and Scotland, 1992-1997

Selected staff		1992	October 1994	1997	% change 92-97
Practice nurse	E&W	9,639	9,643	10,724	11
	S	743	808	968	30
Dispenser	E&W	999	1,018	1,213	21
	S	3.5	9	26	643
Management*	E&W	6,497	6,586	8,771	35
	S	623	900	833	34
Comp. Operator	E&W	1,315	1,672	2,287	74
	S	52	163	190	265
All staff	E&W	54,018	54,897	65,599	21
	S	5,516	5,962	6,505	18

* Job title in England and Wales classified as 'Management & Admin' in 1992, 'Practice Manager' in 1994, and is a combination of 'Practice Manager' and 'Fund Manager' for 1997

Source: (RCGP 1999)

Figures reflect the increasing complexity of management in general practice. Prior to the introduction of GP fundholding, few practices employed more than one 'Practice Manager' and some, particularly the smaller practices, did not appoint above the level of 'Senior Receptionist'.

With the onset of fundholding, practices were given increased budgets for managerial staffing, with some choosing to recruit a 'Fund Manager' in addition to the existing Practice Manager. Others expanded the roles of existing staff to meet new demands, yet others chose to appoint incoming managers above existing staff and/or 'let existing managers go'.

The roles of partners within the management of the practice were also set to change with each fundholding practice being required to have a GP designated as lead partner with respect to the management of the fund. Again, the form this adopted differed by practice with some adopting joint practice and fund management roles, others choosing to specialise in particular management functions.

It was not only fundholding practices that changed their management structures. Pressures generated by new contract working and the associated expansion of health promotion and health surveillance targets created new management workloads for those practices choosing not to join the scheme and for those who were as yet ineligible owing to the size of their practice lists.

The need for 'professional' managers and the distinction between 'administration' and 'management' are stressed by the 'new breed' of practice managers themselves. The fieldwork and available literature have suggested that this 'new breed' of practice manager, or 'general manager' is frequently male. Why is this so? Are the new demands on practice managers perceived as male skills (Bradley 1989) and if so, who perceives them as such?

The increasing emphasis on the 'professional' practice manager adds a new angle on the issues of professional and managerial authority within general practice, with the wider debate as to whether management should be considered a 'profession' having a long history (Child 1969, Reed and Anthony 1992, Watson 1977).

'Practice Management' associations have responded to the above changes by reformulating their 'mission, vision and values' and introducing change in qualification and membership arrangements. There are two national associations that cater for general practice administrative and managerial staff. In 1964 the Association of Medical Secretaries was founded. This later expanded to include receptionists and practice 'administrators', and changed its name to the Association of Medical Secretaries, Practice Administrators and Receptionists (AMSPAR). The Association of Health Centre and Practice Administrators (ACHPA) was formed by a group of health centre and practice 'administrators' in 1975. It now embraces those responsible for the administration and management of practices.

The response of ACHPA has largely been to upgrade the image and skills of existing practice managers. The association changed its name in 1994 to the 'Association of Managers in General Practice'. This was seen as 'a more precise and concise description.' (AMGP:1994). The association states:

'Our purpose is to enhance and promote the standard of *professional* practice management's contribution to patient care, through an effective network of branches, co-ordinated by a strong leadership providing education, training and quality services, leading to greater national recognition' (AMGP 1994:1 *Author's emphasis*)

From April 1995 membership of the association was by qualification in one of the following: AMGP 'New' Diploma; National Vocational Qualification at Level 4 or Management Charter Initiative Level 1.

SUMMARY

It is clear then that the occupation of practice management and the role of management in general practice is in the process of change. Walby has noted that:

The analysis of points of change offers particular insights into gender relations in employment (1986:91).....changes in the organisation of capital often precipitate gender struggles over employment in particular occupations, since they both destabilise the old balance of gender forces and create and destroy particular forms of employment' (1986:88) .

In this thesis it will be argued that the agent of change is the state, with attempts to curtail professional powers and control health spending being the precipitating factors of change in the profile, rewards and gender of managers in general practice.

The bodies of literature contributing to our understanding of these issues are reviewed in the following chapters, commencing with an appraisal of literature relating to the management of professional work in chapter three and a review of the literature on gender and organisational studies in chapter four.

CHAPTER THREE

THE RISE AND FALL OF THE PROFESSIONS

INTRODUCTION

Any attempt to investigate the delivery and management of health care services must address the concept of 'professions' and the nature of work and organisation in developing capitalist industrialism. What follows is an overview of sociological approaches to the analysis of work and in particular to the role and management of 'technical' or 'expert' labour.

3.1 In the Beginning

As Crompton (1990) notes the term 'profession' is not a generic or universal concept, although early sociological analyses frequently treated it as such. Indeed whilst

'In the English language 'profession' has inescapable moral overtones.....in French, for example, the word is a descriptive term translating as 'occupation' (1990:149).'

Some of the earliest references to 'professions' are found in the work of Durkheim, where professions are viewed as a means of counteracting the 'anomie'¹ resulting in modern societies. Durkheim's use of the term 'profession' is very different to the common usage in Anglo-American language to refer to a 'particular' occupation or group of occupations, it being based on his study of Roman and medieval artisan 'corporations', which he argued should be reconstituted to regulate and provide moral direction to individual industrial branches across the country.

¹ As the division of labour increases and becomes more sophisticated new roles are required. Increasing differentiation of units or groupings occur and the uniformity of beliefs and moral ideas decreases leading to societal disintegration or 'anomie'. In modern societies 'anomie' or normlessness is prevented via organic solidarity which is based less on commonality found in pre-industrial societies and more on mutual inter-dependence.

Comprised of both employers and workers within particular occupational settings, such corporations would provide a forum for regulating and agreeing labour relations between employers and employees within the industry and form the link between the industry and the state. Whilst local branches could be developed there would be a central administrative council to bind the 'profession' together.

Potential solution as opposed to existing phenomena, the professional corporation was presented as a scheme for further development by the state. This concept was to play an influential role in future functionalist writings and in particular to the work of Talcott Parsons (1951).

Weber was also to feature strongly in the development of what was to become a 'sociology of the professions' by virtue of his distinction of rational action as a basis for modern bureaucratic organisations and its association with the predominance of 'technical expertise'. Weber believed rational action had become the dominant mode in modern industrial societies via a process of rationalisation, the most important aspect of this process being:

'....the substitution for the unthinking acceptance of ancient custom, of deliberate adaptation to situations in terms of self interest' (Weber 1947:123).

Rational authority produces a certain type of organisational structure, bureaucracy, defined as a hierarchical organisation designed rationally to coordinate the work of many individuals in the pursuit of large-scale administrative tasks and organisational goals:

'The more complicated and specialised modern culture becomes, the more its external supporting apparatus demands the personally detached and strictly 'objective *expert*' (original emphasis), in lieu of the master of older social structures, who was moved by personal sympathy and favour, by grace and gratitude' (Weber in Gerth & Mills, 1948:216).

The ascendancy of technical expertise is emphasised such that:

‘Bureaucratic administration means fundamentally the exercise of control on the basis of knowledge. This is the feature which makes it specifically rational’ (Weber, 1947:339).

Thus in a bureaucracy, access to positions within the hierarchy is achieved on the basis of technical expertise. Power within the organisation is based on the application of rules within the limits of authority determined by position in the hierarchy.

Less developed in Weber’s analysis is the concept of ‘collegiality’, which is presented as a ‘stage in the development of bureaucracy’. Collegiality is also referred to only in the context of the state/ruling administration and not in private enterprise (Gerth & Mills 1948:235).

The specialised knowledge of the expert, it is argued, increasingly becomes the foundation of power for the ‘office holder’ (be this monarch, aristocrat, elected president etc.). To preserve a dominant position the officeholder must, by some means, exploit the power of experts, gaining access to their expertise without conceding authority. Thus, the office holder will draw together a ‘collegiate’ body, drawn from a range of experts within the administration. All members of the collegiate group are equal in status and included on the basis of technical expertise. Decision-making is based on consensus with each member usually having the right of veto. The ‘office holder’ makes the ultimate decision regarding the acceptance or rejection of presented options. In so doing the officeholder gains access to expertise without relinquishing authority.

Collegiate structures are presented by Weber as a relatively weak organisational form that is generally subjected to the will of the ‘non-expert’ office holder. Whilst influential in decision-making, the final authority rests outside the collegiate group.

However, whilst 'collegiate' structures within state apparatuses were seen as having limited powers, Weber identified the power of 'experts' in other settings to halt the process of bureaucratisation. In his comparative analyses of the development of legal systems, Weber draws on the concepts of closure and status group to explain the differential development of the legal system in England and Germany.

'In England the failure of all efforts at a rational codification of law.... was due to the successful resistance against such rationalisation offered by the great and centrally organised lawyers' guilds. These guilds formed a monopolistic stratum of notables from whose midst the judges of the high courts of the realm were recruited. They retained in their hands juristic training as an empirical and highly developed technology, and they successfully fought all moves towards rational law that threatened their social and material position (Weber in Gerth & Mills 1948: 217-218)'.

Weber notes this battle was:

'to a considerable degree economically caused by the lawyers' interest in fees....but the power position of the lawyers who emerged victorious from this struggle, was conditioned by political centralisation (Weber in Gerth & Mills, 1948:217-218).

Thus by closure of the occupation via monopoly of training and control of recruitment, in conjunction with influence in political life on the basis of status group, the lawyers' guild was able to mobilise power against the 'rationalisation' of their sphere of work. Thus Weber identifies the concept of monopoly on the basis of expertise as a means of occupational control, a concept that is commonly dated from the 1960s and referenced in the works of Freidson (1970, 1973, 1984), Johnson (1972) and others.

Whilst relatively under-developed in the works of Weber, being over-shadowed by the writer's concentration on the 'iron cage' of bureaucracy, this thesis will show that the concepts of collegiality, closure and status group offer much to the study of

‘expert labour’ and the use of ‘knowledge’ as a source of power in the labour process.

It is Parson’s later synthesis of the work of Weber and Durkheim that was to form the platform for a study of ‘the professions’ as a distinct entity. Along with Durkheim, Parsons viewed the increasing specialisation and division of labour in a positive light, being a process of achieving the best and most rational means of achieving desired ends.

Parsons, a prominent theorist of the functionalist tradition was to make an influential critique of Weber’s classification of rational-legal authority in claiming a fundamental error in the conflation of the authority of ‘office’ i.e. position in the structure, with the authority of ‘expertise’.

‘Weber’s formulation of the characteristics of bureaucratic organisations, which has become a classic, raises some serious analytical difficulties in the treatment of social structure. It is the present writer’s opinion that he has thrown together two essentially different types which, though often shading into each other, are analytically separate’ (Parsons in Weber 1947:58).

Weber’s ‘expert’ is identified by Parsons as the ‘professional’ worker whose claim to authority is on the basis of a distinct body of knowledge. Such ‘professions’ argues Parsons, are more commonly found in private practice as opposed to large corporations wherein their authority is not conflated with the coercive ‘authority of office’ but, for example in the case of the doctor of medicine:

‘.....getting his orders obeyed depends entirely on securing the voluntary consent of his patient to submit to them’ (Parsons in Weber 1947:59).

Groupings of professionals are rarely found to adopt a hierarchical administrative structure:

‘Instead of a rigid hierarchy of status and authority there tends to be what is roughly, in formal status, a ‘company of equals’ an equalization of status

which ignores the inevitable gradation of distinction and achievement to be found in any considerable group of technically competent persons' (Parsons in Weber 1947:60).

In singling out the 'professions' as distinct occupational groups, guided by a commitment to 'professional ethics' and with an authority based on technical expertise as distinct from and not accountable to the 'authority of office', Parsons and the functionalist tradition succeeded in generating a new direction in the study of *'the professions'*.

3.2 The 'Rise of Professionalism'

The concept of 'profession' was thus established in Anglo-American academic study and the sociological task then became the identification of 'professions' and the 'traits' or 'attributes' which defined them. A proliferation of studies followed, focusing on an analysis of the 'established professions' of law and medicine in order to discover the 'essential traits' of a profession (e.g. Greenwood 1957, Millerson 1964).

In doing so this not only allowed these occupations to define themselves but also to define what it is to be a 'professional'. The functionalist approach, it has been argued, reproduced at the level of sociological knowledge, professionals' own definitions of themselves (Johnson 1972). Most importantly it assisted in setting professionals apart from management based on the 'authority of office'. Such management was seen as inimical to the collegial control systems (Waters 1989) claimed to regulate the professions.

Carr Saunders and Wilson, writing in the early 1930s for example, ask:

'Any attempt to define professionalism would be premature until the material is before us. But what material shall we investigate? There are certain vocations of ancient lineage which by common consent are called professions, law and medicine among the foremost; they are the typical professions and we must start with them' (1933:3).

The resulting conclusions strongly echo Durkheim:

‘Professional associations are stabilizing elements in society. They engender modes of life, habits of thought and standards of judgement which render them centres of resistance to crude forces which threaten steady and peaceful evolution. But the service which they render in so doing is not sufficiently appreciated. It is largely due to them and to other similar centres of resistance that the older civilizations stand firm ...The family, the universities, certain association of intellectuals and above all the great professions, stand like rocks against which the waves raised by these forces beat in vain’ (Carr Saunders & Wilson 1933:497).

As Macdonald notes such analyses:

‘in some cases reach a level of uncriticality that is hard to credit’ (Macdonald 1995:2).

Larson (1977) also emphasizes the difficulties of the trait approach in taking the claims of professions at face value:

‘It is also somewhat disturbing to note that competence and the service ideal play as central a role in the sociological ideal-type as they do in the self-justification of professional privilege...The elements that compose the ideal-type of profession appear to be drawn from the practice and from the ideology of the established professions’ (Larson 1977: xi).

The ‘trait’ approach encountered significant frustration however in its failure to achieve a commonly accepted definition of ‘profession’. There then followed the concept of ‘profesisonalization’ as process, whereby occupations sought to acquire professional ‘traits’ in an ambition to become full ‘professions’:

‘We must think of the occupations in society as distributing themselves along a continuum, from prestigious professions such as physician or attorney through less skilled occupations to the least skilled occupations such as watchman or farm labourer’ (Greenwood 1957:44).

Thus the extent of ‘professionalisation’ of an occupation could be measured against conceptual scales to determine if they were in the words of Etzioni

(1964), 'professions' or 'semi-professions', or more precise still, be measured against a Guttman scale of professionalization (Hickson and Thomas 1969).

The sociological question moved from what is a profession to how 'professional' is an occupation.

Following general criticisms of the functionalist tradition the 'sociology of the professions' was to develop a more critical stance from the 1960s onwards. Sometimes singularly referred to as the 'power approach' critiques were actually developed from a range of perspectives including the Chicago School and symbolic interactionism, Neo-Weberian and Marxist analyses.

A theorist of the Chicago school, Becker argued (1970) that the frustration of the trait approach stemmed from attempts to turn a 'folk concept' into an abstract scientific concept and suggests that instead:

'We view *profession* as an honorific symbol in use in our society and analyse the characteristics of that symbol. In making this analysis we are not concerned with the characteristics of existing occupational organisations themselves but with conventional beliefs as to what those characteristics ought to be. In other words, we want to know what people have in mind when they say an occupation is a profession...the best data for analysis of this symbol would be the findings of research on the meaning of 'profession' to people in our society' (1970:3).

The value of such analyses lay in emphasizing the importance of meaning and action at the micro-level. Becker concludes that in comparing the symbol with the reality of practice in areas such as medicine and law:

'The symbol systematically ignores such facts as the failure of professions to monopolise their area of knowledge, the lack of homogeneity within professions, the frequent failure of clients to accept professional judgement, the chronic presence of unethical practitioners as an integrated segment of the professional structure, and the organisational constraints on professional autonomy. A symbol which ignores so many important features of

occupational life cannot provide an adequate guide for professional activity' (1970: p103).

Becker's recommendation is that educators should more closely relate study to the realities of practice in order to provide:

'a symbol which could provide an intelligible and workable moral guide in problematic situations' (1970:103).

It would appear that Becker, in focusing on micro-level interpretation and semantic use of the 'symbol of professionalism' has underestimated the structural dimensions of professional power, a charge frequently levelled against symbolic interactionist approaches (see for example, Rock P 1979). The 'symbol', whilst perhaps a 'folk concept' has, it is widely recognised, succeeded in accruing considerable privilege and power for certain occupations within the labour market, a factor which professional educators are unlikely to want to undermine.

Freidson, building on the work of both Weber and the Chicago School was able to develop a link between micro and macro levels of analysis in his influential analysis of professionalism as a form of occupational control. Freidson, an early critic of the trait approach, argued that the 'theory of professions' is only one part of what should be attempts to develop a more general and abstract theory of occupations. Rather than viewing the professions as a particular 'type' of occupation, professionalism should be viewed as a strategy of occupational control (1970).

Freidson argued that the professions were organised around what he termed the 'occupational principle' as opposed to the 'administrative principle' in the Weberian view of the rationalisation of society. The source of authority in organisations ruled by the administrative principle is the manager or administrator. Authority is hierarchical and management define the tasks which are to be done and the manner in which they are performed.

In comparison the established professions can be seen to operate via the 'occupational principle'. In a professionalized service the organisation's central task, around which all other supporting activities are organised, is performed and controlled by professionals.

‘When the central strategic task of an organization is formulated, controlled and evaluated primarily by the workers, as it is in the case of the established professions, management does perform logistic functions, but is essentially stripped of what Weber considered to be the prime characteristic of administrative authority – the legitimate right to exercise imperative coordination’ (1973: 24).

Such forms of occupational control are a:

‘.....central manifestation of what is being called the post-industrial revolution, where services take precedence over goods, where factory hands are replaced by machines and where much of what human work is left must be performed by highly trained occupations’ (1973:27).

We shall return to the concept of the ‘post-industrial’ revolution (Bell 1973), this being an area of contention in labour market analysis (Pratt & Lavalette 2001).

The strongest professions, Freidson argued, are able to maintain control over work performance by virtue of the claim that they are the only ones who have sufficient knowledge to evaluate it and are committed to ensuring the maintenance of high standards. Resistance to formal procedures, standards and rules is maintained by the claim that the work is of such a complex nature that standardisation is too arbitrary and individual judgement will always be required. Thus informal collegiate control is established.

The cognitive and normative elements analysed by the trait approach as ‘givens’ which define a profession, are, in Freidson’s analysis, socially constructed elements of an ideology aimed at achieving monopoly in the market.

Rather than being a neutral product of the increasing advance of science and rationality in modernity and a response to emerging social needs and values, the cognitive and normative elements of profession are social constructs, an ideology applied in a process of struggle and persuasion to achieve control over the labour process. As Freidson notes:

‘Knowledge itself does not give special power: only exclusive knowledge gives power to its possessors. And it is precisely in the occupational principle of organisation, by which recruitment, training and the performance of the work of creating, disseminating and applying knowledge are controlled by the ‘knowledge occupations’ that such power is obtained’ (1973:29).

Freidson argues that the state has a central role in granting monopoly:

‘Insofar as privilege is deliberately organised on a legal basis, it has a political foundation. It is the power of government which grants the profession the exclusive right to use or evaluate a certain body of knowledge and skill’ (1973:29).

This relationship must be maintained on an ongoing basis if the occupation is to retain its position in the face of competing claims:

‘Quite apart from the *development* of a profession however, the *maintenance* and *improvement* of the profession’s position in the market place, and in the division of labour surrounding it requires continuous political activity...on the formal associational level, professions are inextricably and deeply involved in politics’ (1973:29).

This was clearly demonstrated in chapter one of this thesis where the shifting balance of power between the state and medical profession was charted across the introduction and re-organisation of a National Health Service.

Freidson further asserts that from a position of achieved monopoly, professions are able to develop a degree of independence from the powers that granted monopoly: the state. Ideology is thus employed to extend the boundaries of occupational control

to define, for example, the way in which health and ill-health are viewed within society (Freidson 1970).

The 'expropriation of health' (Illich 1977) thus finds conditions such as depression and grief brought under the auspices of medical control and treatment. The 'medical model' of ill-health with its emphasis on individual pathology, undertakes diagnosis and treatment of the individual as opposed to possible underlying social causes.

Thus whilst agreeing on the concept of 'profession' as self-serving ideology or 'discourse', Illich saw a larger agenda for the dominant professions than control over the labour process:

'.....the new dominant professions claim control over human needs, *tout court*. They turn the modern state into a holding corporation of enterprises which facilitates the operation of their self-certified competencies.....Many professions are now so highly developed that they not only exercise tutelage over the citizen-become-client, but also determine the shape of his world-become-ward' (Illich 1977 16-17).

Theorists predicted the increasing control of human life by an elite of professional experts (Foucault 1979). Foucault challenged the Marxist conceptualisation of power as a macro-structure that functioned to support industrial capitalism, expressed via channels such as the law, church and education system. In Foucault's conceptualisation, power was dispersed at a micro level, played out in day to day practices.

Foucault attempted to analyse the 'discursive practices' that claimed ownership of knowledge, seeking to demonstrate how the development of knowledge was intertwined with the mechanisms of political power. Unlike Marx, Foucault had no underlying belief in a deep underlying truth or structure: objectivity did not exist.

Foucault focused on the way that knowledge and the increase of the power of the state over the individual has developed in the modern era. In the 'History of

Sexuality' (1979) he argued that the rise of medical and psychiatric science has created a discourse of sexuality as deep, instinctual and mysterious. Such discourses shaped human subject's experience of their own sexuality, ultimately controlling sexual behaviour.

Foucault did not offer any all-embracing theory of human nature or social organisation and was critical of attempts to do so, viewing such narratives as masking the contradictions and instabilities that are inherent in any social organization or practice.

The instrument of capital in Marxist analyses (Esland & Salaman 1980, Johnson 1972), professions contribute to the reproduction of the labour force by masking the essentially exploitative nature of capitalist social structures and assisting in the creation of a 'false consciousness'.

'Post Industrial' theorists saw more positive images of the expansion of the role of 'knowledge workers' in the shift to a 'third stage' in the economy of advanced industrial societies. Thus Bell (1973) identified a progression from a traditional society based on agriculture to industrial society based on modern manufacturing industry and then to post-industrial society where the emphasis on the production of goods is overtaken by the service economy.

Bell envisaged that knowledge would become the source of innovation and social organization. The occupational structure would shift from blue collar to white collar employment and knowledge would become increasingly important in production, consumption and leisure. The dominant capitalist class would be replaced by a technocratic elite who would control the companies they worked for, separating ownership from control, the former being retained by capitalists.

Bell's analysis has been heavily criticised for over-stating changes in the economic base of industrial societies and misrepresenting the nature of work in a service

economy where intrinsic job satisfaction, higher rewards and 'self-actualisation' are the experience of a small proportion of all employees (Pratt 2001)².

3.3 Professions in Decline

From protectors of moral values (Parsons) to self interested occupations (Freidson 1970, 1973) through to established cults (Illich 1977) and a 'new knowledge class' (Bell 1973) professions have taken on a range of guises all of which have emphasized, positively or negatively, their considerable power and growing influence within the social structure.

The common thread in more recent analyses has, conversely, identified a decline in professional powers. Initially dominated by an analysis of the medical profession in America, theories of diminishing professional power have flourished in the UK largely as a result of a shift in approach to the management of public services introduced by Conservative administrations from the late eighties onwards.

A dominant strand in theories of the declining power of professional groups was developed by McKinlay et al (1985, 1988) in their analysis of the medical profession in the USA. McKinlay and Arches (1985) base their analysis on claimed parallels between the shift to employment of clinicians in large scale organisations and the transition of craft workers from pre-industrial to capitalist modes of production; a process which is also described as 'strikingly similar' to Weber's theory of 'bureaucratisation'.

Thus in the pre-capitalist period, small scale independent craftsmen operated domestic workshops, sold the products of their labour in a free market and controlled the production of their goods. The transition of the craft worker to the factory and the exchange of labour for wages led to the surrender of ownership of the means of production and eventual loss of control over the process of production as work was

² Manufacturing has never been a majority employer in the UK with the exception of a brief period in the 1950s. Falls in employment are also explained by the globalization of production where labour is displaced overseas, thus still being a significant component of developed economies.

progressively rationalised via an increasingly complex division of labour and increased mechanization of production.

The 'same process', it is argued, is described by Weber in the development of the bureaucratic organisational forms in which a hierarchical structure is managed by a strict chain of command, an elaborate division of labour of qualified individuals, working within the remit of detailed rules and regulations etc.

The extent to which Weber and Marx are in fact describing the 'same process' is open to question, however the present focus is on the value of McKinlay's analysis that:

'The processes outlined by Marx and Weber with respect to a different group of workers, during a different historical era, is directly applicable to the changing situation of doctors today, now that the "industrial revolution has finally caught up with medicine" (George Rosen). Whereas, generally speaking, most other workers have been quickly and easily corporatized, physicians have been able to postpone or minimize this process in their own case' (1988: 197).

A number of changes are identified in the US health care sector which have resulted, it is argued, in physicians being:

'severely reduced in function and their formerly self-interested activities subordinated to the requirements of the highly profitable production of medical care' (ibid).

The increasing involvement of multinational corporations in the health care sector is identified as the key factor in the changing position of professionals. Thus, the involvement of private sector interests in medical manufacturing, ownership and financing of treatment organisations and medical insurance etc. and the increasing trend towards mergers in these sectors is leading to the concentration of medical service in large, profit seeking organisations. This trend has been referred to by others as the 'corporatisation' of health care (Salmon 1995).

The introduction of 'Diagnostic Related Groups' (DRGs) for Medicare patients in which hospitals are reimbursed by diagnosis with rates determined by the government has meant that hospitals have the opportunity to make profits where costs are kept below the reimbursement rate, and correspondingly suffer losses where treatment costs are exceeded.

'These regulatory efforts, corporate mergers, investor owned hospital chains, federally mandated cost-containment measures, among many other changes, are transforming the shape, content, and even the moral basis of health care' (McKinlay et al 1988, 192).

The authors identify a number of responses including the introduction of 'new management', a process of 'specialization and de-skilling', over supply of doctors and unionisation.

A 'new breed of physician administrators' is identified, termed by Alford as 'Corporate rationalisers' (1975). Some have medical qualifications but most, it is claimed, are trained in hospital administration with an emphasis on rationalisation, productivity and cost efficiency.

'Displaced by administrators, doctors have slipped down to the position of middle management where their prerogatives are also challenged or encroached upon by other health workers. Increasingly, it seems, administrators, while permitting medical staff to retain ever narrower control of technical aspects of care, are organizing the necessary coordination for collaborative work, the work schedules of staff, the recruitment of patients to the practice, and the contracts with third party purchasers, and are determining the fiscal rewards' (McKinlay et al 1988:192).

In addition, it is argued, increasing specialization of physicians is limiting the range of work they can legitimately perform. Whilst doctors themselves may view specialization as a positive process, they are in fact, being 'deskilled' as in Braverman's analysis (1974).

Specialization and task delegation, argues McKinlay, reduces management's dependence on highly trained medical staff and enables the introduction of lower skilled, lower paid health workers such as nurse practitioners. In turn such groups seek their own autonomy within the division of labour and increasingly pursue the right to perform tasks without the direction of physicians, a strategy supported, it is argued, by management.

The concept of the 'health care team' undermines the superior position of the physician:

'Nowadays, physicians are required to work alongside other professionals on the 'health care team'. The ideology of *team work* (original emphasis) is a leveller in the hierarchical division of health care labour. Other workers - for example physiotherapists, pharmacists, medical social workers, inhalation therapists, podiatrists and even nurses in general - may have more knowledge of specific fields than physicians, who are increasingly required to defer to other workers' (McKinlay et al 1988,193).

The 'gate keeping' role of physicians is also being weakened, it is argued, by nurses and pharmacists who are now able to prescribe a limited range of medications in certain states within the USA.

The increasing specialization of physicians has also led to fragmentation in their representative bodies with physicians choosing to affiliate with bodies representing their own specialism, with membership of the AMA falling. Such fragmentation it is argued, weakens the political position of doctors and limits their influence over policy decisions. The authors estimate that less than half of all doctors in the USA are now members of the AMA.

Oversupply of doctors is also leading, it is argued, to a weakening of their control over the market place. Over-supply renders fee for service 'solo practice economically less feasible' and reduces the bargaining position of those employed.

The authors point to a shift from solo practice to employed status and estimated that over half of US doctors were in salaried arrangements in 1988.

‘Physician oversupply and the associated economic vulnerability may force doctors to accept lower incomes and the increasingly alienating work conditions practising in HMOs, clinics and hospitals of “today’s corporate health factories”, just as 19th century craftsmen accepted the factory floor forced on them by their move to the industrial plant’ (McKinlay et al 1988:195).

Increased interest in unionisation is reported with several unions being formed in different areas of the USA. The authors quote an ophthalmologist Aaron Nathensen as expressing a ‘widely held’ view that:

‘When I entered the practice 15 years ago, unionisation was thought of as totally unprofessional, un-medical and un-American. But there’s a growing feeling that we’re losing control of the health industry’ (in McKinlay et al 1988:196).

Thus it is argued that the position of professions within the labour process is becoming increasingly ‘proletarianized’, a theory which:

‘seeks to explain the process by which an occupation category is divested of control over certain prerogatives relating to the location, content, and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism’ (1988:200).

Seven ‘professional prerogatives’ are lost or curtailed in this process as follows:

1. The criteria for entrance (e.g. the credentialing system and membership requirements)
2. The content of training (e.g. the scope and content of the medical curriculum)
3. Autonomy regarding the terms and content of work (e.g. the ways in which what must be done is accomplished)
4. The objects of labour (e.g. commodities produced or the clients serviced)
5. The tools of labour (e.g. machinery, biotechnology, chemical apparatus)

6. The means of labour (e.g. hospital buildings, clinic facilities, laboratory services)
7. The amount and rate of remuneration for labour (e.g. wages and alary levels, fee schedules).

The authors stress that the term 'proletarianization' denotes a *process* in which the power and cohesiveness of an occupation group, the stage of production associated with the sector and the extent to which tasks can be 'technologized' influence the end outcome.

Acceptance of the proletarianization thesis pre-supposes the validity of the general account of progressive proletarianization of the labour force in advanced capitalist societies and the identification of this process with Weber's ideas of bureaucracy.

The expansion in professional and white-collar employment are not easily accommodated in Marxist theory where the dichotomous interpretation of class make it difficult to recognise the existence of a 'middle class' (Giddens 1973) leading to theories of a 'service class'³.

The 'proletarianization thesis' has been criticised at a number of levels. Freidson (1984) whose analysis is also based predominantly on the position in the United States, has argued that the proletarianization thesis attributes too much significance to structural changes in the labour market position of physicians, focusing on the shift from solo practice to employment in large corporations.

³ Distinguished from other classes by four key features, trust, code of service, security of employment and prospects of material advancement. (See Goldthorpe 1980, 1982, 1995).

Self-employment in a competitive market-place, argues Freidson, involves less security, less autonomy and lower rewards than employment in a sector in high demand:

‘Owning property or the means of production, whether it is a professional practice or a shop, is not important in and of itself in assuring control over one’s economic fate and autonomy in one’s work. But if one’s goods or services are not in heavy demand, then one will be confronted by indifferent consumers and at best will live a life of dignified starvation. Whether one is employed or self-employed is beside the point. Given a strong position in the market, one can be employed and “write one’s own ticket” nonetheless’ (1984:9).

Whilst professions are increasingly being drawn into large bureaucracies their future autonomy, according to Freidson, will rest on the ability of management to break down and compartmentalise work in such a manner as to achieve control of the actual content and process of work: an achievement Freidson viewed as extremely unlikely.

Derber (1983) argues that the proletarianization thesis requires further refinement in order to fully explain the nature of ‘dependant professional employment’. Derber distinguishes between two forms of proletarianization, technical and ideological, relating to the means and ends of labour respectively.

Technical proletarianization refers to:

‘The lack of control over the process of work itself (i.e. the means) incurred whenever management subjects its workers to a technical plan of production and/or a rhythm or pace of work which they have no voice in creating (1983: 313)’.

Derber echoes Freidson in maintaining that the technical aspect of professional work has been left relatively intact despite a move to paid employment:

‘Professionals, unlike industrial workers, have salvaged from dependant employment what has emerged as the bedrock of their self-respect and unique status: a considerable measure of preservation of their technical skills and continuing control of highly specialized knowledge’ (1983: 317).

Ideological proletarianization refers to:

‘..the appropriation of control by management over the goals and social purposes to which work is put. Elements of ideological proletarianization include powerlessness to choose or define the final product of one’s work, its disposition in the market and its uses in larger society, and the values or social policy of the organisation which purchases one’s labour’ (1983: 313).

It is this area, argues Derber, that the position of professionals in the labour process has been undermined.

‘Salaried physicians, social workers, and attorneys, employed by corporations or profit-making social agencies, for example, may find that institutional profit imperatives lead to basic organisational practice and goals not consistent with their own service ideals.....professionals employed in the public sector, experience their own distinctive forms of ideological proletarianization in which their work is subverted by the requirement of serving state interests’ (1983:324).

Derber identifies two responses to ideological proletarianization: ideological desensitisation in which workers dissociate themselves from the ideological context of their work, and ideological cooptation where individuals redefine their goals to suit ‘institutional imperatives’ (1983:325).

Ideological proletarianization may be the first step in the same historical process experienced by craft workers, however Derber argues, in the absence of any current evidence for technical proletarianization, the ideological form may yet be:

‘a new system of labour process control in ‘post-industrial’ capitalism that does not require the technical proletarianization of workers in order to effectively subordinate them to capitalist production. Technical knowledge and skill controlled by workers is fundamentally inimical to capitalist production only if workers perceive their interests as different from

management and are organized in a manner to enforce their own objectives' (1983:335).

Based predominantly in an analysis of the American health care sector, analyses of the declining power of professions have emphasized the role of private capital in the degradation of professional work. In comparison UK analyses have paid greater attention to the role of the state in health care, with a large volume of literature emerging in response to recent changes introduced not only in the health care sector, but across public services in general.

One feature of this corpus of work in the UK is the claim that we are witnessing a 'new managerialism' in the approach to public services and the professionals within this sector. A key theme in this work is the suggestion that reform of the public sector is not simply or primarily about controls on economic expenditure but is more directly aimed at curbing professional power (Ackroyd and Soothill 1994, Clarke and Newman 1993), being the result of a combination of macro economic issues as well as political ideologies (Harrison 1988). The 'new managerialism' is frequently cited as having its ideological roots in the 'New Right' or 'Neo-Liberal' wing of the Conservative party, with new and significant forms of control over the organisation and management of professional labour having been introduced from the mid 1980s onwards.

3.4 Public Sector Reform and Professional Power

Chapter One outlined the demographic and economic trends which led to the NHS reforms of the late 1980s and early 1990s. As in other developed economies, spiralling costs of publicly funded health care, driven by clinician led advances in medical technology and an increasingly aging population were placing significant pressures on the public purse.

As care was free at the point of delivery, consumers of health care were unlikely to ration their demand, whilst providers of health care both defined market need and delivered the solution within a professional model of health care.

Klein thus identifies an inherent conflict:

‘between the professional providers and the paternalistic rationalisers: between the medical profession and the policy nexus of Ministers and civil servants. Oversimplifying, the conflict was between those who saw the aim of the health service as being to provide doctors with sufficient resources to pursue the professional imperative of maximising treatment for the individual patient and those who saw the aim of the health service as being to distribute inevitably scarce funds in such a way as to reconcile the competing claims of different groups for resources’ (1996:64).

Whilst hospital funding was limited to some extent by the allocation of overall budgets, spend in the primary care sector, in ophthalmic, dental and general medical practice was, as chapter one outlined, effectively open ended. As independent contractors, GPs had no limits over the number of patients they could refer or costs of drugs they prescribed. Thus as Klein notes:

‘The irony of the NHS as set up in 1948, and perpetuated since, was precisely that it could exercise least control over the gatekeepers to the system as a whole: the general practitioners, through whom all referrals to hospitals were channelled’ (1996:33).

Rationing of health care within the NHS was thus undertaken on an implicit basis via the individual clinical decisions of health professionals, made with an awareness of available resources. This approach relied on the cooperation of clinicians, whom Harrison et al argue, expected resources available to the service to continue to rise. ‘Cost improvement’ programmes and explicit rationing in the form of state decisions to limit procedures available on the NHS challenged the right of health professionals to determine the allocation of health resources and proved, argues Harrison et al (1994), to be politically dangerous.

The radical changes introduced, not only in health care but across public sector provision, from the late 1980s have been viewed by many (Walby 1994, Ham 1997 Pollitt 1993) as a concerted campaign, not only to control public spending but also to curtail professional powers.

Harrison et al (1994) in common with many others identify the 'New Right' or 'Neo-liberal' ideology underpinning the Conservative administration as being the driving force behind reforms, holding to:

'....a body of theoretical beliefs which portrayed public services as inefficient, costly monopolies which used their influence over information to ensure that more services were provided than the average voter wanted to afford. Within this unflattering portrait the public service professionals were singled out for particular criticism. Set in their ways, it was suggested that such professionals used their job security as a basis for empire building and resistance to those who wished to reform them. From their entrenched professional strongholds they were also able to ensure that the *content* of the services they provided was shaped by their own predilections more than by what governments or the citizens using these services might actually want' (1994: 7).

Earlier reforms had concentrated on cost savings via policies such as the Financial Management Initiative and Cost Improvement Programmes, resulting in cost savings but at the expense of an increasingly demoralised and militant body of public sector workers. Claims made by high profile professionals that the 'NHS was in crisis' added to the pressure from public opinion which Klein and others identify as an important factor in the change of emphasis, to the language of quality and market orientated consumer led services found in the reforms of the late 1980s and early 1990s.

Reforms in this period are commonly linked with an 'ideology' of managerialism', defined by Pollitt as:

'..a set of beliefs and practices, at the core of which burns the seldom-tested assumption that better management will prove an effective solvent for a wide range of economic and social ills' (1993:1).

Pollitt identifies a number of specific beliefs associated with managerialism:

- Increases in economically defined productivity are the key to future social progress
- Productivity increases will come from the application of technology including information and organisational technologies as well as 'hardware'
- The application of technologies will require a labour force 'disciplined in accordance with the productivity ideal' (Alvesson 1987:58)
- Management is a separate organisational function which plans, implements and measures improvements in productivity
- Managers must be given the 'freedom to manage'.

(Adapted from Pollitt:1993:2)

This set of beliefs, argues Pollitt, has come to achieve increasing ascendancy in the late twentieth century with management theorists, academics and politicians alike, claiming an increasingly broad agenda for 'management' and the 'manager':

'Efficient management is a key to the [National] revival...And the management ethos must run right through our national life – private and public companies, civil service, nationalised industries, local government, the National Health Service (Heseltine, 1980 in Pollitt 1993:3).

Bradley et al (2000) note the precedence of 'management' in shaping the agenda for sociological studies in the work place. The development of 'Business Schools' within academic institutions has strengthened the links between industry and education with research subsequently pursuing the resolution of 'management problems', blocking out the voice and experience of the worker and underestimating worker resistance.

Clarke (1993) traces the roots of 'managerialism' to analyses of the decline of the American economy in the late 1970s.

'The managerialisation strategy did not spring fully formed from the hydra head of new right think tanks or the Thatcher cabinet. It draws on a set of analyses and prescriptions which were developed about the failings of the American economy in the late 1970s. These were expressed in the domains of 'economics' and 'management' and offered parallel messages that economic decline could be defeated through an onslaught on the individual, corporate and national blockages to enterprise' (Clarke et al 1993:51).

Often linked with the concept of managerialism are perceived changes in the form of capitalist economy. Post Fordist theorists argue that a major transition has taken place in Western societies away from bureaucratic forms of management control in the production of mass produced goods to more flexible organisation structures and working practices in which differentiated goods are produced for niche markets.

Driven, it is argued, by increasing globalization of markets brought about by developments in technology and communication, the 'post-industrial' organisation requires greater flexibility, innovation and responsiveness:

'The time horizons of private and public decision-making have shrunk, while satellite communication and declining transport costs have made it increasingly possible to spread those decisions immediately over an even wider and variegated space' (Harvey 1989: 147).

Whilst fordism was production-led, post-fordism is defined as being consumer-led. Producers increasingly target defined market segment with commodities being marketed on the basis of lifestyle and image factors as much as the utility of the product.

Advancements in technology reduce the labour intensity of production and 'semi skilled machine minders' are replaced with smaller, multi-skilled workforces more engaged in the labour process (Burke 2000).

Management methods move towards the active engagement and participation of workers in quality control, with increased accountability for managing one's own performance and reward systems based on individual appraisal. The cultivation of an appropriate 'organisational culture' in which workers identify with the goals and objectives of management as being in the joint interest of all is the pinnacle of the new approach to 'Human Resource Management' (Peters and Waterman 1982). Functional flexibility is combined with numerical flexibility⁴ involving the casualisation of the workforce and enabling capital to respond to the dynamics of the market-place in terms of product diversity and flexibility in labour costs.

Some have identified the increased opportunities for fulfilling employment (Piore and Sable 1984) whilst others have noted the disproportionate volumes of the labour market engaged on the 'periphery' of post-fordist enterprises (Gilbert et al 1992).

Central to the concept of post-fordism then is a shift from 'mass' systems to more differentiated, fragmented systems in terms of labour processes, products, markets and labour forces. The concept has been applied in the analysis of change in the public sector whereby monolithic, bureaucratic services delivered by the state and led by producer orientated professionals, have seen the introduction of market mechanisms which have created a split between 'purchaser' and 'provider' functions with the latter operating as 'proxy consumers' in a market which is led by local demand.

The theory that advanced capitalist economies have entered a 'third' phase involving a significant shift in the organisation and deployment of capital has been heavily criticised for overestimating both the extent of 'fordist' production and 'post-fordist'

⁴ Core workforce supplemented by peripheral labour in the form of part time, fixed term contracts, casual labour and outsourcing of 'non strategic' elements of production.

forms. Thus it is argued that a diversity of strategies have been employed by capital in the search of profitability in any one period (Sayer and Walker 1992).

The validity of the theory in explaining changes in the management of the public sector has also been questioned. Thus, as Clarke notes, the adoption of the thesis would presuppose that the previous state structures can accurately be described as fordist, a factor disputed by the labour intensive as opposed to mechanized labour process involved in service delivery. Further, as has been widely noted, the public sector, whilst producer rather than consumer led, is identified as enabling a significant degree of autonomy and individuality in professional practice (Clarke 1993).

Clarke concludes:

‘The application of ‘post fordism’ to the analysis of emergent state forms carries the danger of either technological or economic reductionism and (depending on the variant of the thesis taken) risks underestimating the political struggles involved in attempting to develop and accomplish particular strategies of restructuring’ (Clarke 1993:48).

Closer analysis of policy would indeed suggest a more complex picture than that suggested by the ‘binary options of fordism and post fordism’ (Clarke 1993:48).

The language of policy makers in the reform of public service provision has emphasized the devolvement of decision making, giving ‘front line workers’ the ‘freedom to manage’, freeing them from the bureaucracy of state control and enabling the best services to thrive in an open market-place.

However, at the same time as organisation structures are being decentralised and fragmented with increased freedom to manage funds and resources at a local level, central control over the monitoring of output, efficiency and quality has increased via the imposition of tightly defined output and performance targets.

‘One of the paradoxes of contemporary management is that it both liberates and enslaves. Whilst operational managers may be given real control over the resources necessary to do the job right the centre (of the firm or government) retains control over strategic questions such as the framework of financial and personnel rules and performance targets within which devolution over operational matters is allowed to occur (Hogget 1994:3).

Fragmentation via the introduction of the market and separation of purchaser and provider roles has promoted the dismantling of bureaucratic controls, whilst increasing surveillance at the centre via the pursuit of ‘neo-Taylorist performance standards and ‘quality control’.

‘Taylorism was centrally concerned with the ‘processes of determining and fixing effort levels’ and can be seen as the bureaucratisation of the structure of control but not the employment relationship. It proceeded on the basis that previously unmeasured aspects of work process could and should be measured, by management, and then used as the basis for controlling and rewarding effort...This is not so far, in principle, removed from the recent epidemic of electronically mediated public service systems of performance indicators, individual performance review and merit pay’ (Pollitt 1990:16).

Thus the shift in the balance of GP remuneration from capitation fees (fee per registered patient) to itemised service units and achievement of service targets such as immunisations, screening services and health promotion clinics, have been seen as incursions of the state into the form and content of professionals work.

This has escalated over the last decade culminating recently in the publication of hospital league tables in the mass media, detailing post-operative survival rates and waiting times etc. ‘Failing trusts’ are threatened with the replacement of the management team whilst positive performance is rewarded with increased funding.

Thus it is argued that the discourse of managerialism has legitimated increased surveillance and control of professional activity via the introduction of centrally driven performance targets and ‘quality improvement’ strategies.

As in the post-fordist organisation however, the strategy of 'incorporation' (Ackroyd and Soothill 1994, Klein 1995) has also been employed such that professionals are encouraged to internalise the agenda and role of 'management'.

As highlighted by earlier studies of professional work, the ideology of managerialism finds itself in direct conflict with the concept of occupational control and collegiate forms of work organisation, in which the individual practitioner is free to practice as he/she deems fit based on qualification in a discreet body of knowledge and adherence to professional codes of conduct.

The introduction of resource management in the secondary sector and GP fund holding in primary care have sought to place clinicians in the position of budget holder, with direct accountability for expenditure of cost limited budgets.

The Fund-holding initiative charged GPs with allocating a finite budget for a fixed range of secondary and community care services to best meet the needs of the practice population, as opposed to individual patient. Offering practitioners the 'freedom' to purchase services as they saw fit, the fund-holding initiative therefore introduced the first cash limited budget into general practice and involved professionals in overt resource rationing:

'For governments undergoing a prolonged period of fiscal crisis and budgetary constraint, operational decentralisation combined with tight centralised expenditure control constitutes a subtle method of passing difficult rationing decisions down the line not only to service managers but to various publics themselves' (Hoggett 1994:4).

Thus the literature identifies three strategies in recent policy change. Firstly attempts have been made to replace or transform 'administrators' into 'general managers'. Secondly policy initiatives such as resource management, clinical budgeting and fund holding in general practice, have attempted to turn clinicians into managers and thirdly, discourses of decentralisation and consumer driven services have been

accompanied by increased surveillance and control at the centre via the imposition of detailed performance targets and budget capping.

SUMMARY

This chapter has provided an overview of the concept of professions within sociology and social policy. As this review has shown, the 'professions' have had a somewhat chequered history in social analysis, from protectors of moral values (Parsons) to self-interested occupations (Freidson 1970, 1973) through to established cults (Illich 1977) and a 'new knowledge class' (Bell 1973). The professions have taken on a range of guises all of which have emphasized, positively or negatively, their considerable power and growing influence within the social structure.

Later analyses have emphasized a decline in professional power, resulting in neo-Marxist approaches, from the desire of capitalism to control the labour process (Mckinlay et al 1988) and in UK policy analyses, from the State's agenda to ration and control limited public resources. The relevance of theories of proletarianization have been questioned in regard to the structure of UK primary health care, in which the vast majority of GPs retain self-employed status as sole practitioners or in partnership with other clinicians. Whilst influenced by the values and practices of private capital, it has been argued that the agent of change in the UK is the State, which has sought change in the organisation and control of clinical work via the imposition of policy initiatives against the collective will of the profession.

Building upon the work of Weber (1947) and Freidson (1970) amongst others, this thesis takes the position that 'profession' is a means of occupational control, employed by an occupational group to achieve power in the labour process. Chapter one outlined the collective agency of an occupational group in achieving a strong structural position of monopoly contractors in a state funded health service.

Analysis presented in this chapter has suggested that at the level of collective bargaining, professional authority has indeed been challenged. The weakness of

policy analyses is, however, their focus on the macro-level at the expense of more detailed study of the impact of policies on the ground. Chapters six to eight will move on to demonstrating how the 'occupational principle' of control within general practice, supported by the structural position of GPs as employers of managerial staff, has enabled the 'profession' to resist 'managerialist' agendas at the micro level.

In focusing on the conflict between professional and managerial values, studies of the management of professional work have rarely considered the implications of policy change on the gendering of managerial occupations, an issue which emerged as an important factor in this study. The following chapter considers the contribution of existing theory to our understanding of women's position in the labour market.

CHAPTER FOUR

GENDERING THE WORKPLACE

INTRODUCTION

The original focus of the research underpinning this thesis was an analysis of relationships between ‘managers’ and ‘professionals’ in primary health care, with a view to investigating claims of a decline in professional power discussed in previous chapters. In studying the impact of policy change at practice level it became evident that gender was a key factor in explaining the experience of managers within the sector and the rewards and opportunities open to them. Both quantitative data and qualitative interviews pointed to a process of occupational change in which the role, rewards and status of managers were being thrown into question and where gender was playing a significant part in the subsequent re-definition of the occupation. The need to adopt a ‘gendered perspective’ in analysing the changing remit and identity of the ‘Practice Manager’ therefore became clear, which implies:

‘..analysing the importance, meaning and consequences of what is culturally defined as male or masculine as well as female or feminine ways of thinking (knowing), feeling, valuing and acting. A gender perspective also implies an analysis of the organisational practices that maintain the division of labour between the sexes’ (Alvesson et al 1997:7).

This chapter provides an overview of the literature relating to women and work and the extent to which existing theory contributes to our understanding of the management of clinicians in primary care.

4.1 The Sexual Division of Work

As Bradley notes,

‘....anthropological and historical evidence bears testimony to an almost infinite variety of forms of sexual division of work’ (1989:8).

The ‘sex-typing’ of jobs and segregation of the work force on the basis of gender is a persistent phenomenon. ‘Sex-typing’ and ‘segregation’ are distinguished by Bradley as follows:

‘By sex-typing, I mean the process by which jobs are gendered, ascribed to one sex or the other; while segregation refers to the way in which women and men are located in different types of jobs’ (1989:9).

The well established distinction between the concentration of women in particular occupations (horizontal segregation) and in lower levels within occupations (vertical segregation) was made by Hakim in 1979 (1979:19) and has been consistently demonstrated in empirical studies of women and work (Bradley 1989, Cockburn 1983, Kanter 1977).

Significant increases in women’s education and engagement in paid employment have occurred since the earliest of these studies, leading some to identify major ‘transformations’ (Walby 1997) in gender relations and employment, resulting in a greater role for women in the public sphere. Change however, is also tempered by much continuity in the persistence of gender divisions in employment:

‘The system of gender relations is changing, from one which was based on women being largely confined to the domestic sphere, to one in which women are present in the public sphere, but still frequently segregated into unequal positions’ (Walby 1997:1).

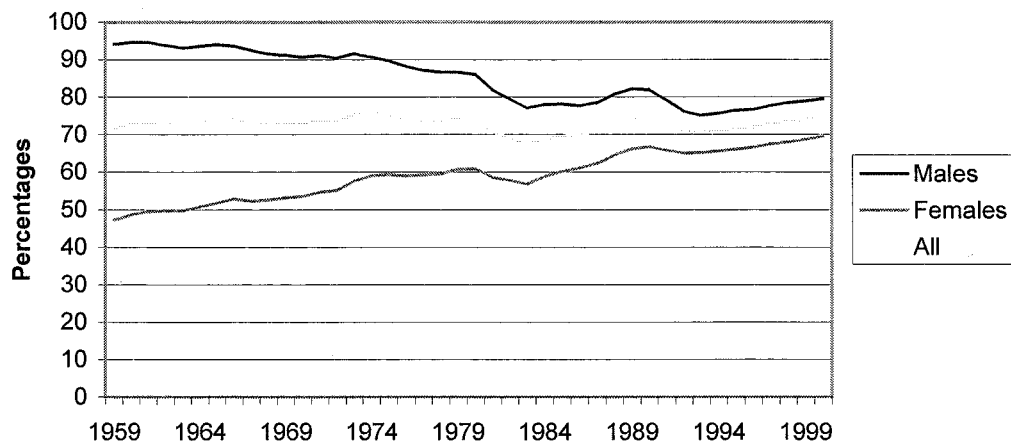
Analysis of labour market statistics demonstrates the large-scale entry of women into employment, and their concentration in particular sectors and positions.

4.2 UK Labour Market Trends

Approximately three quarters of the total working population are in employment, varying from between 70% and 75% between 1959 and 2000, with no signs of any significant long-term change in employment rates.

Overall rates mask significant differences by gender however, with male employment showing a gradual decline since the mid 1960's compared with an increase in rates for women from 47% to 70% between 1959 and 2000.

Figure 4-1: Employment Rates by Gender



At Summer each year. In 1959 to 1971, males aged 15 to 64 and females aged 15 to 59; from 1972 onwards males aged 16 to 64 and females aged 16 to 59.

Source: Department for Work and Pensions (Chart 4.1 ONS, Social Trends 32:70)

Table 4.1 overleaf shows the rise in women's participation in the labour market from 10 million in 1971 to 13.2 million in 2001; this rise has been greatest for those women aged 25 to 44, followed by those aged 45 to 54. As the rates of participation in further and higher education have increased, so the engagement of both males and females aged 16 to 24 in the labour force has fallen.

Table 4-1: Labour Force by Gender

United Kingdom						Millions	
	16-24	25-44	45-54	55-59	60-64	65 and over	All aged 16 and over
Males							
1971	3.0	6.5	3.2	1.5	1.3	0.6	16.0
1981	3.2	7.1	3.0	1.4	1.0	0.3	16.0
1991	3.1	8.1	3.0	1.1	0.8	0.3	16.4
2001²	2.4	8.3	3.4	1.2	0.7	0.3	16.3
Females							
1971	2.3	3.5	2.1	0.9	0.5	0.3	10.0
1981	2.7	4.6	2.1	0.9	0.4	0.2	10.9
1991	2.6	6.1	2.4	0.8	0.3	0.2	12.4
2001²	2.0	6.6	3.0	1.0	0.4	0.2	13.2

1 The former civilian labour force definition of unemployment has been used to produce estimates for 1971 and 1981; in later years the ILO definition has been used and members of the armed forces excluded.

2 At Spring.

Source: Census; Labour Force Survey, Office for National Statistics (Social Trends 32 Table 4.5:72)

4.2.1 Type of Employment

Looking at the type of employment undertaken by women, again change sits alongside familiar patterns. Female domination of the part time labour force continues. A total of 5.8 million employees worked on a part time basis in 2000, of whom 4.8 million were female. Two fifths of all women in employment (40%) work on a part time basis compared with 7% of men. Part time employment is typically associated with low paid occupations, exclusion from career hierarchies and training opportunities (Walby 1988).

Table 4-2: Population of working age by employment status and gender, spring 1986 and 2001

	1986			2001		
	Males	Females	All	Males	Females	All
Economically active						
In employment						
Full-time employees	11.3	5.3	16.6	11.8	6.4	18.3
Part-time employees	0.3	3.9	4.2	1.0	4.8	5.8
Self-employed	2.0	0.6	2.7	2.2	0.7	3.0
Others in employment ²	0.3	0.1	0.4	0.1	0.1	0.2
All in employment	13.9	10.0	23.9	15.2	12.1	27.3
Unemployed ³	1.8	1.2	3.1	0.9	0.5	1.4
All economically active	15.8	11.2	26.9	16.0	12.6	28.6
Economically inactive	2.2	5.3	7.5	3.1	4.8	7.9
Population of working age	18.0	16.4	34.4	19.2	17.4	36.6

1 At Spring each year. Males aged 16 to 64, females aged 16 to 59.

2 Those on government employment and training schemes and unpaid family workers.

3 Based on the ILO definition. See Appendix, Part 4: ILO unemployment.

Source: Labour Force Survey, Office for National Statistics (Social Trends Table 4.3:71)

4.2.2 Occupation

The most common occupations among women employees continue to be in the clerical and secretarial sphere, followed by personal and protective services. For men there was a fall of 4 percentage points between 1991 and 2000 in those working in craft and related occupations, reflecting the decline in manufacturing industry. The proportion of male managers and administrators is still nearly twice that of women, with both men and women seeing an increase of 3 percentage points in this area of employment.

Table 4-3: Employees by gender and occupation, 1991 and 2000

United Kingdom	Percentages			
	Males		Females	
	1991	2000	1991	2000
Managers and administrators	16	19	8	11
Professional	10	12	8	10
Associate professional and technical	8	9	10	11
Clerical and secretarial	8	8	29	25
Craft and related	21	17	4	2
Personal and protective services	7	8	14	17
Selling	6	6	12	12
Plant and machine operatives	15	14	5	4
Other occupations	8	8	10	8
All employees ² (=100%)(millions)	11.8	12.8	10.1	11.0

1 At Spring each year. Males aged 16 to 64, females aged 16 to 59.

2 Includes a few people who did not state their occupation. Percentages are based on totals which exclude this group.

Source: Labour Force Survey, Office for National Statistics

4.2.3 Women in Management

The Equal Opportunities Commission (20022) report that women account for 30% of all Managers and Senior Officials, making up a higher proportion of managers and proprietors in agriculture and services (36%) than the generally higher paid corporate managerial occupations (28%).

Table 4-4: Employment in selected managerial occupations in Great Britain, 2001

Thousands	Women	Men	Female %
Corporate Managers	815	2,087	28
Corporate Managers & Senior Officials	24	93	21
Directors and chief Executives	*	53	*
Production Managers	32	517	6
Production, Works and Maintenance Managers	26	339	7
Functional Managers	286	778	27
Financial Managers & Chartered Secretaries	55	131	30
Marketing and Sales Managers	92	340	21
Advertising and PR Managers	20	25	45
Personnel, Training and Industrial Relations Managers	67	50	57
I-CT Managers	34	169	17
Quality and Customer Care Managers	34	68	33
Financial Institution and Office Managers	178	150	54
Financial Institution Managers	48	82	37
Office Managers	130	68	66
Managers in Distribution Storage and Retailing	137	364	27
Retail and wholesale Managers	123	228	35
Protective Service Officers	*	71	*
Health and Social Services Managers	120	45	73
 Managers and Proprietors in Agriculture and Services	 299	 540	 36
Managers in Farming, Horticulture, Forestry and Fishing	*	34	*
Managers and Proprietors in Hospitality and Leisure Services	126	154	45
Restaurant and Catering Managers	58	78	43
Managers and Proprietors in other Service Industries	165	353	22
Shopkeepers and Wholesale/retail dealers	69	134	34
All Managers and Senior Officials	1,114	2,628	30

Notes: * Less than 10,000 in Cell

Source: Office for National Statistics (ONS) Labour Force Survey; Spring 2001

Men outnumber women in nine out of the eleven managerial sub-groups with the exceptions being financial institutions and office managers, women predominating in the latter function. Four fifths (79%) of Corporate Managers and Senior Officials are male as are 94% of Production Managers. In terms of functional specialism, women are most likely to be found in HR (57% of all HR managers) and Advertising/PR roles (45%).

Female managers are also more likely to be found in the public (40%) than private sector (28%), comprising 30% of managers in public administration and defence, 50% of managers in education and 67% of managers in Health and Social Work

Data from the National Management Salary Survey, an annual survey of the salaries of managers in the UK first conducted in 1974, indicates that women accounted for one in ten of all Company Directors in 2001, comparing with 0.6% in 1974. Progress is most marked in the period 1995 to 2000 during which time the proportion of female directors more than trebled, with female heads of department and section leaders almost doubling. Whilst these figures demonstrate a shift in the position of women they also add weight to the Equal Opportunities Commissions conclusion that: 'managerial occupations remain strongly gender segregated' (EOC 2002:2).

Table 4-5: Female share of managers in UK, 1990-2001

	1974	1990	1995	2000	2001
Director	0.6	1.6	3	9.6	9.9
Function Head	0.4	4.2	5.8	15	15.8
Department Head	2.1	7.2	9.7	19	25.5
Section Leader	2.4	11.8	14.2	26.5	28.9
All executives	1.8	7.9	10.7	22.1	24.1

Source: Institute of Management and Remuneration Economics,
National Management Salary Survey

Entry into managerial positions has not brought equality of pay; in Spring 2001, women who were employed full-time as managers and senior officials earned £12.23 per hour on average, compared with the average male rate of £16.03. This equates to a gap of 24%, wider than that found in all other occupational groups (E.O.C 2002:5).

Such analyses therefore point to systematic and persistent patterns of inequality between men and women in the labour market that are not adequately explained by the differential capital individuals bring to the labour market in the form of skills and qualifications.

4.3 Explaining Gender Divisions

Following a period noted for the invisibility of women in sociological analyses of work and industrial relations, the field of enquiry has expanded significantly to embrace a wide range of perspectives.

Early attempts to theorise the position of women in society attempted to 'add in gender' to Marxist materialist accounts of the division of labour. Theses such as the 'Domestic Labour Debate' (Secombe 1974) and the 'reserve army of labour' (Beechey 1977) explained gender inequality by the needs of capital to appropriate women's domestic labour for the reproduction of labour, whilst also drawing women into the labour market as a reserve army of labour, called upon in times of boom to meet labour requirements and prevent the inflation of wages via a shortage in labour supply.

Such theories commonly reduce women's position in the labour market to their position in the home. It is argued that women's responsibilities in the home limit and shape the opportunities available to them in the labour market (Doeringer and Piore 1971, Edwards et al 1975, Barron and Norris 1976, Braverman 1974) These approaches have been criticised for failing to recognise the active organisation of

men in the workplace which can shape and limit women's participation. Furthermore such theories are not supported by analyses of labour market participation.

As Bradley notes:

‘Such approaches continued to see women’s position solely in terms of the needs of capital. There was insufficient recognition that men as a social group, might also profit from the inferior position of women in employment or their assignment to domestic duties’ (Bradley 1989: 57).

Functionalist theories have similarly reduced women’s position in the labour market to their domestic commitments. Human capital theorists (e.g. Mincer 1966) assume a perfect labour market where individuals bring human capital in the form of qualifications, skills and experience which have a certain market value. The ‘household’ makes rational decisions regarding the most appropriate division of labour. As women adopt the homemaker role they spend less time in the labour market, thus building less experience and gaining fewer qualifications. The achievement of qualifications is lower due both to a lack of time to pursue them and the expectation that they will not be required. Lower ‘human capital’ therefore means that when women choose to enter the labour market, they are confined to less skilled employment with lower rewards.

Whilst commonly employed by the respondents in this study as a means of explaining wage differentials of managers in primary care, such theories cannot be sustained both in terms of the overwhelming empirical evidence which demonstrates that pay does not have a linear relationship with ‘human capital’ and studies which clearly evidence that the very concept of ‘skill’ is a social construct which some groups have consistently more authority to define (Cockburn 1983, Bradley 1989, Acker 1990, Witz 1990).

Attempts to place men within the equation of gender inequality have led to the development, in various forms, of the concept of a social system of 'patriarchy'. The term Patriarchy has on the whole, been poorly defined and loosely applied in the literature. Some theorists argue that patriarchy is a system of inequality in which men dominate women (Walby 1986, Hartman 1981) Others have argued that patriarchy can only be applied in the narrower context of domination of the father over women and younger men (Mitchell 1975).

In much the same manner as Marxism assumes the economic infrastructure to ultimately shape all other relations, radical feminists have identified gender as a singular structure upon which all other social relations are built. A key theme in such analyses is the control of women's bodies via reproduction (Firestone 1974) rape (Brownmiller 1976) and the definition and control of women's sexuality (Leeds Revolutionary Feminists 1981). The main weakness of such theories is the tendency towards biological reductionism and as Walby notes, a tendency to confuse empirically evidenced 'effects' of male domination as root causes (1986:27).

Others have attempted to include both patriarchy and capitalism as dual structures in determining social relations. Some allocate the systems to different levels, or spheres e.g. capitalism to the economic and patriarchy to ideology (Mitchell 1975) whilst others identify the two as co-existing in all spheres and levels of society (Hartmann 1976, Walby 1986, 1990, 1999).

Hartmann identifies patriarchy as a separate system pre-dating the introduction of capitalism:

'I want to argue that before capitalism, a patriarchal system was established in which men controlled the labour of women and children in the family and that in so doing men learned the techniques of hierarchical organisation and control' (1976:137).

Industrialisation threatened men's control over women's labour since it could offer financial independence from men. Thus men:

‘.....acted to enforce job segregation in the labour market; they utilised trade union associations and strengthened the domestic division of labour, which required women to do housework, child care and related chores. Women's subordinated position in the labour market reinforced their subordinate position in the family, and that in turn reinforced their labour market position’ (1976:137).

Whilst the base of the capitalist system is defined as economic, the basis of a system of patriarchy is less clear in the literature. Some have allocated it to the superstructure, others have described it as all embracing and some would argue that is so ill-defined as to be inadequate as an explanatory construct (Bradley 1999).

In responding to such criticisms Walby argues for a distinction on the basis of social relations as opposed to institutional form. Thus:

‘At issue is how to provide the basis of the distinction between patriarchy and capitalism. I would suggest that the search for an institutional basis of the separation is misplaced. Rather it is the distinctiveness of the social relations of patriarchy and capitalism which is the crucial means of separating them. Patriarchy is distinctive in being a system of interrelated structures through which men exploit women, while capitalism is a system in which capital expropriates wage labourers. It is the mode of exploitation which constitutes the central difference between the two systems...These social relations exist at all levels of the social formation, whether this is characterized as economic, political and ideological, or as economy, civil society and the state or whatever (1986:46)’.

Walby goes on to identify six autonomous structures of patriarchy which have causal effects upon each other:

‘Patriarchy is composed of six structures: the patriarchal mode of production, patriarchal relations in paid work, patriarchal relations in the state, male violence, patriarchal relations in sexuality and patriarchal relations in cultural institutions’ (Walby 1990: 20).

The patriarchal mode of production refers to men's appropriation of women's domestic labour whilst relations in paid work involve the exclusion and segregation of women into certain types and level of occupation via the collective and individual actions of men.

The state is identified as having 'patriarchal interests in its policies and actions' evidenced in a range of policies such as the marriage bar on women's employment, the barring of women from certain occupations and enforced dependence on men via the structuring of the welfare system.

Male violence, it is argued, 'is behaviour routinely experienced by women from men, with standard effects upon the actions of most women' (1990:21), whilst sexual patriarchal relations involve 'compulsory' heterosexuality and the sexual double standard'.

Institutions such as education, religion and the media reproduce the representation of women creating 'gender differentiated forms of subjectivity'.

With the increasing entrance of women in to the labour market Walby argues that the dominant form of patriarchy has shifted from the private to the public sphere, from the home to the state and workplace. Strategies of excluding women from the workplace have shifted to an emphasis on segregating women within the workplace, where expropriation is collective, rather than individual at the level of the spouse or partner (see figure 4-2 overleaf).

Figure 4-2: Private and public patriarchy

Form of Patriarchy		Private	Public
Dominant Structure		Household production	Employment/State
Wider Patriarchal structures		Employment	Household production
		State	Sexuality
		Sexuality	Violence
		Violence	Culture
		Culture	
Period		C19th	C20th
Mode of expropriation		Individual	Collective
Patriarchal strategy		Exclusionary	Segregationist

Source: Walby 1990:24

Witz has alternatively combined the Weberian concept of occupational closure and patriarchy in her analysis of the division of labour in medicine. The 1858 Medical Act is seen as one of the turning points in the 'professional project' of medicine, making it an offence to falsely claim qualification in medical practice, with the existence of a register serving to distinguish between the qualified and unqualified practitioner. The requirement that holders of public posts were practitioners on the register effectively barred women from such employment as the means of attaining qualification via universities, medical corporations and teaching hospitals were closed to women.

Witz (1990) identifies 'gendered strategies' which are tactics played within a patriarchal structure. Such tactics include exclusionary, inclusionary, demarcatory and dual closure strategies. Exclusionary and demarcatory strategies are employed by dominant groups to exclude subordinate groups from opportunities and rewards

in the case of the former and to create and control occupational boundaries with related occupations in the case of the latter.

‘A gendered strategy of exclusionary closure is one which is exercised by a dominant social collectivity, men, which serves to create women as a class of ineligibles. It secures for men privileged access to rewards and opportunities in the occupational labour market. This strategy employs gendered collectivist criteria of exclusion vis a vis women and gendered individualist criteria of inclusion vis a vis men’(1990:125).

Responses by subordinate groups can take the form of ‘inclusionary’ strategies where the aim is to gain access to the opportunities and rewards denied, or ‘dual closure’ strategies where subordinate groups seek their own professional project via registration and credentialing for independent occupational areas.

Thus women seeking careers as public medics employed inclusionary strategies in efforts to gain access to the credentialing systems of the medical profession. Direct attempts to win such access failed with access finally being achieved via parliamentary means in the 1876 Enabling Bill which outlawed exclusion on the grounds of sex, although not requiring that Universities accept women.

Thus whilst it is generally recognised that the state is instrumental in creating professions via the licensing of occupational groups, it has been shown to weaken occupational closure on the base of gendered work relations in this context.

Witz identifies nursing as a key example of dual closure strategies in the campaign to achieve nurse registration. Women (the majority gender) aimed to:

- Establish a centralised means of control, over occupational structure to achieve occupational monopoly and control of supply
- Achieve self-government having a majority and direct representation on a central nursing body

- Achieve a one-portal entry via central control over curriculum and the length and standard of training.

These aims challenged capital in the form of the employing hospitals who controlled training, terms and conditions, clinicians who had achieved management of nursing activity via demarcatory practices and therein challenged existing gender relations where predominantly male clinicians controlled the labour process of predominantly female nurses.

Witz notes:

‘The notion of a female professional project directs our attention to the fact that there is nothing inevitable about the relative positioning of women within sets of capitalist and patriarchal relations, and more specifically within gendered occupational divisions of labour, but that relations of dominance and subordination are contested relations (1990:131)’.

It is argued that structuralist theories have underplayed the agency of individuals and organisations in shaping social relations, creating them as subjects constrained by pre-existing and independent structures. Witz, in later work with Savage et al asserts that:

‘Social structures do not exist in some abstract sense, ‘out there’, but only insofar as they are instantiated in specific practices’ (Savage et al 1992:7).

Post-structuralist theories have emphasized difference, fragmentation and variation, and the need to study social life at the micro (individual) or meso (organisational) level.

‘There is a tendency in macro theories to objectify women (and men). They are regarded as passive reproducers of existing structures. This makes it difficult to conceive of women as actors on the historical scene – and it also makes it difficult to understand variations in women’s situations (Alvesson et al 1997).

‘Organisational studies’ has emerged as a separate discipline in the study of organisational form and practice. Whereas sociological study has typically focused on macro explanations of social behaviour such that capital and/or patriarchal forces determine the social division of labour and labour market process, organisation theorists have focused at the meso level, at the form and content of organisational life.

Such study has often focussed on instrumental ends to achieve more efficient organisational forms. Savage et al summarise the focus of organizational studies pre-1980s as:

‘A well funded and well-resourced subject largely staffed by male academics servicing male managers and geared to thinking about specific organizational problems’ (Savage et al 1992:4).

As in much of mainstream sociology, early study of organisations has neglected the issue of gender:

‘Masculine dominance in academic as well as organisational life has had an important influence on the kinds of questions raised and the answers subsequently produced in management and organisation studies...It has been implicitly assumed and communicated that organisations are neutral to gender or that it is a man’s world. The manager is assumed to be a ‘he’...It is the life and work of men that has been considered the research standard, both within the human relations school, strategic management research, cultural theory or any other known schools and fields for organisation theory’ (Alvesson et al 1997:6).

One of the earliest analyses to address the experience and position of women within the discipline of ‘organisation studies’ was developed by Kanter, who viewed organisations as ‘gender neutral’ environments in which contingent gender relations are played out. ‘Contingent’ approaches argue that the *principle* of bureaucratic organisation is gender-neutral, even where organisations are demonstrably not gender neutral in practice. Counter to much of the management literature of the day which explored ‘male’ and ‘female’ styles of management, Kanter argued that

gender inequality in the workplace was the result of the dynamic of bureaucracy, which encourages managers to recruit in their own likeness, reflecting and reinforcing gender relations that are pre-existent and independent of the workplace.

‘It is the uncertainty quotient in managerial work, as it has become defined in the large modern corporation, that causes management to become so socially restricting; to develop tight inner circles excluding social strangers; to keep control in the hands of the socially homogenous peers; to stress conformity and insist upon a diffuse, unbounded loyalty; and to prefer ease of communication and thus social certainty over the strains of dealing with people who are “different”’ (1977:49).

Whilst providing a detailed insight into the ways in which exclusionary practices are played out within organisations, Kanter’s analysis is limited by its failure to explain the underlying distribution of power, as noted by Walby:

‘Kanter’s work is a complex and sophisticated account of the construction of the cultural roles played by men and women within the workplace against a backdrop of a wider framework of society. However, its stress upon the norms, ideas and expectations is at the expense of an analysis of the macro-structures of power and of struggle’ (Walby 1986:32).

Thus leading to a somewhat vacuous analysis where men achieve position of power ‘because they have power’; leaving the latter unexplained:

‘If the much greater desire for men as leaders in organisations does not reflect real sex differences in style and strategy, what does it reflect? As we have seen people often prefer the *powerful* as leaders.....a preference for men is a preference for power, in the context of organisations where women do not have access to the same opportunities for power and efficacy through activities or alliances’ (1977:200).

Rather than viewing bureaucracy as ‘gender neutral’ others have argued that it is an essentially masculine concept, based on a specifically male way of doing things. Building on both Weber and Foucault, Ferguson (1984) has argued that the ‘discourse of bureaucracy’ as rational, efficient and impersonal is based on

masculine values and characteristics developed during socialization and embedded in the male dominated public sphere:

‘It is not just the case that women’s voices are muted within the bureaucratic discourse and their modes of acting and relating to others submerged within bureaucratic structures, but also that bureaucratic discourse and structure are masculinist and antithetical to feminist modes of organising’ (in Witz and Savage, 1992:20).

The presentation of organisations as ‘gender neutral’ serves to reinforce and mask inequalities:

‘Their gendered nature is partly masked through obscuring the embodied nature of work. Abstract jobs and hierarchies assume a disembodied and universal worker. This worker is actually a man: men’s bodies, sexuality and relationships to procreation and waged work are subsumed in the image of the worker. Images of men’s bodies and masculinity pervade organisational processes, marginalizing women and contributing to the maintenance of gender segregation in organisations’ (Acker 1990: 139).

It is noted that much analysis of organisations has focused on the bureaucratic form of organisation as the omnipotent form in advanced industrial societies. Such emphasis have served to mask the wider experience of work situated in other forms of organisational structure and in particular, the ‘company of equals’ found in general medical practice. Recent theories of a shift from fordist to post fordist organisation have been critiqued for assuming previous dominance of the former organisation structure.

A trend is now developing in the field of ‘organisational studies’, as in other areas, to adopt a multi-faceted understanding of organisations as ‘socially situated practice’ (Halford et al 1997). Conceived of in this way, organisations are the result of past struggle and negotiation between the agents of which they are comprised:

‘Organisational structures, practices and cultures are devices by which past forms of agency are in a sense ‘stored’. In as much as structures practices and cultures remain constant, the effect of past agency is continuously reactivated,

and even where change takes place it is on terrain defined by previous 'organisation' (Halford et al 1997:18).

Thus individuals both act upon and are constrained by the organisations of which they are a part. An 'embedded' approach to understanding organisations therefore emphasizes that 'organisations cannot be understood as depersonalised systems' (Halford et al 1997:15).

Whilst it has long been recognised that organisations may have both 'formal' and 'informal' structures (Crozier 1964) the former have been conceptualised as 'rational, impersonal and systematic', whilst the latter are the product of human resistance, emotion etc.

'Embedded approaches' identify formal organisational processes as the product of human agency, driven by a range of motivations and shaped in part by the agency of those they seek to 'organise'.

Based in an empirical analysis of restructuring across three sectors, Halford et al emphasize the active role of human agency in determining organisational life, driven by a range of motivations and not simply capitalist pursuit of increased profitability.

'Our approach emphasises that restructuring is tied to the people who comprise organisations since it is these people who define, implement and contest restructuring strategies (albeit not necessarily under conditions of their own making). Simultaneously, we emphasize that, far from simply changing *structures*, which then impact on employees, restructuring is tied up with redefining and contesting the sorts of personal *identities* and *qualities* which are seen as desirable or undesirable for organisational members to possess' (1997: 65).

In an analysis of the position of Nursing within recent restructuring of acute care in the NHS, Halford et al identify a number of dynamics at work in influencing the distribution of authority and rewards in new structures. Critical of analyses, which

have 'held apart' nurses and restructuring placing the former as wholly the subject of the latter, Halford et al identify nurses as agents in the process of change:

'Restructuring is presented as something that 'happens to' nurses...there is little appreciation of what we term 'embedded restructuring'. Decision-making and change are not being carried out 'to order' by passive employees of the NHS as a result of political directives from above. Rather the work of nursing is being conducted within a changing organisational context and nurses are *part* of this change' (1997:94).

Identifying significant differences in the approach and outcome of restructuring in two NHS Trusts the authors emphasize the impact of individuals on organisational structures. A conflict between the cultures of managerialism and professionalism was identified as in other areas of work, with the former being identified as having masculine overtones by the nurses interviewed:

'Although there was still a lot of senior women in nursing, more and more men were seen to be coming in at the new managerial levels, and running through many of the interviews was the sense, if not explicit association that the values of the new managerialism were fundamentally masculinist ones, literally embodied in the new breed of male managers. In this type of account managerialism was linked to a preoccupation with masculinist values centring on the rational, quantitative, decision-making criteria of budgets. Nurse professionalism was contrasted to this through reference to more feminised values centering on the intangible, qualitative and relational criteria of a job well done by a nurse for a patient' (1997:98).

Finding much resonance with data from the current empirical work, there was much 'talking down' of nurses' ability to manage, often linked to the perception that *women* cannot manage. Reference to the ad-hoc and unsystematic 'coping management' styles of nurses can be viewed, from a different perspective, as under-resourcing in the face of increased demand (Davies, 1995) rather than as reflected in interviews with Senior Managers conducted by Halford et al, as an inward looking professional culture 'drivelling endlessly about the profession' (1997:101).

Diversity in the perception of restructuring on the part of nurses as identified in this study also warns against the tendency in many structuralist approaches to assume a common fate and identity for women in the labour market.

Such analyses present a radical shift from the roots of 'management studies' where the pervasive, unexplored assumption is that 'leadership is synonymous with men' (Collinson and Hearn 1996:6).

4.4 Management Studies: 'Think Manager, Think Male'

Schein made the above, oft quoted, observation in a study of the gendering of managerial work in 1976. Two decades later, Collinson et al identify little change:

'Most managers, in most organisations in most countries are men. Yet the conditions, processes and consequences of men's historical and contemporary domination of management have received little scrutiny' (Collinson et al 1996:1).

Early works such as 'The Organisational Man' (Whyte 1956) and 'Men Who Manage' (Dalton 1959) both reflect and recreate the perception that 'management' is a male domain (Collinson et al 1996:4).

Green et al. observe that much literature in the field of management studies is: 'overly descriptive, atheoretical and heavily reliant upon the gender differences model' (1996:169).

Such 'gender centred perspectives' have explained women's behaviour and under-representation in senior positions as a result of their individual characteristics including personality traits, cognitions, attitudes etc. Thus women are socialized into patterns of behaviour which conflict with the demands of managerial roles (Green et al 1996). Echoes can be found in theories of human capital that assume the fair trade of qualifications, and experience for reward in the labour market.

‘Masculine’ and feminine’ styles of management are defined and measured in the ‘gender differences’ literature (e.g. Birdsall 1980, Chusmir 1985), the latter typically being associated with ‘hard skills’ a command and control approach, a distancing of personal feeling and emotion from the ‘professional’ management role. In contrast, ‘feminine’ management styles are more communicative, caring with an emphasis on people or ‘soft’ skills. Built upon the concept of bureaucratic organisation where rationality replaces emotion and patrimonial authority, the place of masculinity and men is firmly rooted in the leadership of modern organisations.

Attempts to operationalise the concept of feminine and masculine modes of management have met with similar difficulties to the trait approach in the study of ‘the professions’, which attempted to distinguish professional and non-professional workers. A vast array of characteristics and attributes has been studied with much research failing to confirm the ‘difference’ thesis when male and female managers are matched for education and organisational level (Green et al 1996, Hall Taylor 1997).

What is enduring however, as in the trait approach to the professions, is the *perception of difference*, in this case that women are less likely to possess the qualities required by management. As Brenda Hall Taylor concludes:

‘Although the debate around sex/gender differences has attempted to produce conclusive evidence that such differences either do or do not exist, the results have been inconclusive. Such a large body of research has not, however been without an effect on women. ...the debate has served a number of important functions . Among these have been the creation of a space in which to raise the possibility of difference and then to name the possible differences. Once named the differences have been allocated on the basis of sex and begin to appear as fact’ (1997:260).

Recent developments in management theory have seen increased interest in ‘softer’ management skills with an emphasis on ‘transformational’ as opposed to transactional leadership skills. The shaping and management of emotion and the engagement of worker commitment to corporate goals are central to the thrust of

‘new wave management’ (Peters and Waterman 1982); skills typically associated with ‘feminine’ styles of management.

It is noted that such shifts have not resulted in major improvements in the representation of women at senior management levels:

‘Qualities associated with males have been valued and those associated with females have been under-valued, only to be ‘re-discovered’ and added to traditionally male qualities’ (Green et al 1996 170).

And indeed have been shown to create further male advantage:

‘The image [of a caring man] allows the colonisation of certain attractive parts of femininity in order to re-centre rather than de-centre masculinity and further marginalize the feminine by creating a more complete version of masculinity (Linstead 1995:200).

Attempts by women to adopt ‘masculine’ approaches have, it is argued, met with limited success. Weisel (1991) documents the defence presented by the company Price Waterhouse to allegations of sex discrimination where failure to award partnership was justified on the grounds of the employee being too ‘unladylike’ and ‘macho’ in her behaviour.

Skills are thus socially constructed and valued differently according to the gender of the holder:

‘...masculine and feminine behaviours have different personal and social significances when acted out by male and female subjects. What is valorised in patriarchy is not masculinity but *male masculinity* (Threadgold et al 1990 in McDowell 1997:157).

In a study of the financial services sector, McDowell emphasises the continual negotiation and reconstruction of gendered identities:

‘Occupations are not empty slots to be filled, nor do workers enter the labour market and the workplace with fixed and immoveable gender attributes. Instead these features are negotiated and contested at work....Jobs are not gender neutral – rather they are created as appropriate for either men or women, and the set of social practices that constitute and maintain them is constructed so as to embody socially sanctioned but variable characteristics of masculinity and femininity.... formal organisation structures and informal workplace practices are not gender neutral but are saturated with gendered meanings and practices that construct both gendered subjectivities at work and different categories of work as congruent with particular gender identities’ (McDowell 1997:25-26).

4.5 Linking Structure and Agency

Whilst postmodernist analyses have rejected the concept of ‘grand theory’ and post-structuralists have focused on micro-relations and the agency of individuals in shaping interaction, others have called for a re-thinking of social structures as ‘systems’ to a less essentialist concept of ‘dynamics’ which both constrain human action but are also influenced by it. Bradley thus calls for:

‘an account *both* of the ‘lived relations’ of gender and class, conceived of in terms of current economic arrangements and structures of power at work, *and* of the meanings that working people impute to such lived relations and utilize to transform them, as exemplified *both* in the cultures of the workplace and processes of social identification’ (Bradley 1999:10).

Developing Giddens resource based model of power, Bradley defines power: ‘very broadly as the capacity to control patterns of social interaction’ (1999:33). Thus there are many forms of power including class power, racial power, state power and gendered power within which various resources are deployed. Forms of power are referred to as ‘dynamics’ rather than ‘structures’, being fluid and changeable as opposed to static ‘self-sustaining systems’.

In Bradley's model, gendered power refers to the 'capacity of one sex to control the behaviour of the other', a broad concept within which a number of relations are possible, patriarchy being but one and involving the capacity of men to control women. A number of resources are deployed within gendered power including:

Economic Power: the control of economic resources

Positional Power: power and authority gained by holding positions such as employer, manager, supervisor, head of household etc.

Technical power: the deployment of technical expertise and mechanical competence

Physical power: the deployment of physical strength

Symbolic power: the ability to impose one's own definitions, meanings values and rules on a situation

Collective power: the facility to organise groups of people to pursue common goals

Personal power: utilisation of personal resources such as strength of character, knowledge, ability, etc.

Sexual power: control of sexual resources such as physical attractiveness or sexual harassment

Domestic power: control of household goods and materials, domestic skills and expertise.

(From Bradley 1999:34-36).

Thus whilst there are consistent patterns of social interaction which are demonstrable at the macro level e.g. the persistence of sexual divisions of labour in which men predominantly secure positions of seniority and power in the workplace, macro accounts:

'....offer a generalized and abstract of power which conceals variations, complexities and irregularities. For example, while at societal level power may generally take the form of male dominance over women, it is possible (and empirically observable) that in certain contexts some women exercise domination over some men' (1999:31).

The merits of drawing together different levels of social action are significant, enabling analysis to move away from the essentialism frequently encountered in structural analyses whilst also avoiding the nihilism often found in postmodernist approaches. This work is further explored in chapter nine where its utility in explaining the experience of managers and clinicians in primary care is assessed.

SUMMARY

Recent developments in gender and organisational analysis offer much to the current investigation of change in general medical practice, where the balance of power to define and control the labour process and determine occupational rewards have been negotiated, and contested at political, occupational and individual levels.

Empirical research must surely lay to rest the view that gendered patterns of participation and rewards in the labour market are merely a reflection of the differential human capital that women bring to the labour market, or that women are simply the pawns of capitalist enterprise which is driven purely by economic interest alone.

That women's position in the labour market and their experience of the labour process is in part shaped by the interests and will of men has been consistently and powerfully demonstrated by empirical study.

Yet the dichotomy of gender and capital are not sufficient to explain the multi-dimensional reality of social life in which other factors such as age, ethnicity and sexual orientation amongst others play a role in shaping the experience and rewards of individuals.

Further whilst consistent patterns of inequality endure we must also acknowledge the capacity of individuals to engage with and act upon the social world such that

prevailing notions of acceptable and unacceptable behaviour and physical constraint on individual action changes over time.

Bradley's (1999) concept of forms of power as fluid and changeable dynamics rather than static 'self-sustaining systems' is an attractive proposition, developed from the work of Giddens and being grounded in the study of gender and organisations which enables us to bridge the gap between structure and action in explaining social life. This concept is explored further in later chapters.

As in other fields, gender, management and organisational studies have tended to focus on the experience of work within large-scale organisations based on the 'administrative principle' of occupational control.

'Typically it is with the managerial function that organisational power formally (and often informally) resides. In most contemporary organisations, managerial prerogative in key decisions remains the taken-for-granted norm. Whether decisions concern strategic issues of capital investment, product development, pricing, market position and so on, or human resource matters such as recruitment, supervision, promotion, appraisal and training, managements influence over these practices remains unquestioned and unchallenged even by the trade unions' (Collinson and Hearn et al 1996:11).

As a 'company of equals' the modern general practice differs significantly in form and structure to the private sector enterprise or large-scale public body most frequently researched in studies of work and gender. This thesis therefore offers insight into the lives of female managers in a sector that is under-researched and in the throws of change.

This review of existing literature has demonstrated the diversity of the subject studied, embracing a range of disciplines and sites of analysis. In analysing the experience of managers and clinicians in general practice we need to draw together and link the insights gained from each discipline in order to arrive at an analysis which reflects the complexities involved. These insights have included:

- Contributions from the study of professions and expert labour that have demonstrated the ways in which professional workers have established a dominant position within the labour market which enables significant control over their own labour process and that of other occupational groups
- Analyses of policy change which have offered theories of the motivation and intent of policy makers in their challenge of professional powers
- Studies of managerialism and management which illuminate the conflict between professional and managerial values
- Contributions from the fields of gender and organisational studies which, particularly in recent times, have brought the identity of the worker to the fore in analysing the ways in which occupations become defined and controlled.

The challenge is to draw upon the insights offered by these disparate disciplines in producing an account of change in general practice which embraces the 'total picture': from state imposed change to grass roots relationships and the negotiation of roles between occupations and genders.

The following chapter provides an account of the methodology employed in this study before moving on to a detailed analysis of the views and experience of managers in primary care and a rethinking of theory to meet the challenges presented.

CHAPTER FIVE

WAYS OF KNOWING

INTRODUCTION

Commencing with an overview of the history and delivery of the project, this chapter outlines and evaluates the methodology adopted by the study and the epistemological and theoretical assumptions underpinning its development. An account of the ethical issues raised during the work is presented, alongside a review of how the study could be improved.

5.1 The Research Programme

The primary research undertaken for the PhD formed part of a funded study of 'Human Resource Management in Primary Health Care' (reference 872/RO37) in which the author was employed as the sole research assistant, supporting a senior academic team. The objectives of the two projects (and the original PhD focus) are distinguished in figure 5.1 below.

Figure 5-1: Research objectives

	Project 872/R037 Human Resource Management in Primary Care	PhD: Original Focus	PhD: Revised Focus
Objective	Contribute to the debate on changing management practice in the health service by investigating the function of human resource management (HRM) in general practice, a hitherto neglected area.	Extend this project to explore in greater detail the actual implementation of HRM and the views of practice staff on their management and supervision.	Explore relationships between clinicians and managers and the management function within general practice, in the context of radical changes in health care policy
Method	Large-scale postal survey	Depth interviews with managers, clinicians and practice staff	Depth interviews with managers and clinicians
Authors role and contribution	Research assistant, contributing to design, administration, statistical analysis, reporting and publication.	Not pursued	Main researcher and author, responsible for data collection analysis and reporting under guidance of PhD Supervisor.

As noted in figure 5.1, the original focus for the PhD was to be an extended study of the management of paid employees within general practice. This shifted to a focus on the more general management function and the relationship between clinicians and managers for two key reasons:

- Data from the postal survey revealed an interesting shift in the gender and work history of managers entering practice management following the introduction of the new contract and GP fund-holding scheme. Increased male presence, higher salaries and entry of managers from the private sector did not appear, however, to be linked with an increase in managerial authority. These emerging themes opened new and exciting avenues for analysis with a focus on the relationship between clinicians and managers rather than the distinct function of human resource management and the management of practice staff.
- Experience at phase one and trial interviews with practice staff indicated that the feasibility of extended fieldwork with practice staff was limited, owing to the high workload pressures and low staffing levels within general practice.

Thus the emphasis of the PhD changed in order to pursue emergent themes, focusing on the relationship between clinicians and managers in primary care and leaving behind the focus on human resource management. The PhD thesis drew on findings from the phase one postal survey, delivered in conjunction with project 872/R037, and extended this analysis via depth interviews with clinicians and managers; the latter being conducted, analysed and reported by the author.

There follows a review of the epistemological and theoretical underpinnings of this study, prior to a detailed and reflective assessment of the methods employed.

5.2 Ways of Knowing

This thesis explores the relationship between genders, occupations and the state in a period of radical change in health care policy. The methodology is based upon the stance of much recent analysis in the field of organisational and related studies that in order to achieve a complete picture it is necessary to develop:

‘an account *both* of the ‘lived relations’ of gender and class, conceived of in terms of current economic arrangements and structures of power at work, *and* of the meanings that working people impute to such lived relations and utilize to transform them, as exemplified *both* in the cultures of the workplace and processes of social identification’ (Bradley 1999:10).

Decisions regarding research methodologies rest on a number of, often unexplored, assumptions about the researcher’s understanding of what human knowledge is (epistemology), and the assumptions about reality that we bring to the work (theoretical perspective). Crotty (1998) thus identifies four basic elements of the research process:

Methods: the techniques or procedures used to gather and analyse data related to some research question or hypothesis

Methodology: the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes

Theoretical Perspective: the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria

Epistemology: the theory of knowledge embedded in the theoretical perspective and thereby in the methodology.

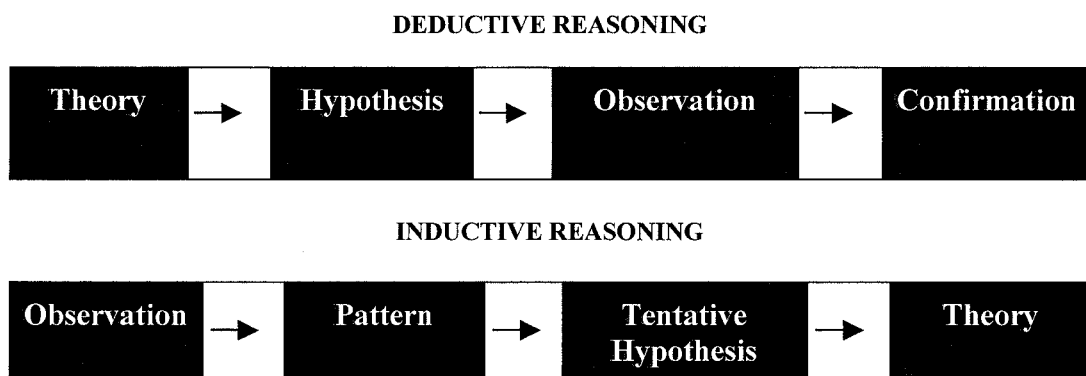
(Crotty 1998:3)

That this work sought to identify ‘the meanings that working people impute to lived relations’ clearly indicates a ‘constructionist’ epistemology, rejecting the objectivist premise that there is an ‘objective truth’ independent of the consciousness of human beings that can be discovered by the application of appropriate methodologies. Rather, this work is predicated on the belief that:

‘Truth, or meaning, comes into existence in and out of our engagement with the realities in our world. There is no meaning without a mind. Meaning is not discovered, but constructed’ (Crotty 1998:9).

At the time of the research very little academic study had been undertaken into management within primary health care; this work did not therefore commence with a ‘theory’ to ‘test’, but a desire to ‘find out more’ about management in general practice. Principally adopting an inductive approach the study was exploratory in nature, using both quantitative and qualitative techniques to investigate the current status and practice of management, through which patterns were identified and investigated. This compares with deductive approaches which commence with a theory from which a specific hypothesis is generated and tested.

Figure 5-2: Deductive and inductive reasoning



Adapted from Trochim 2002

However it can be argued that the traditional distinction between these two approaches is somewhat overstated since as Trochim notes:

‘Even though a particular study may look like it is purely deductive (e.g., an experiment designed to test the hypothesized effects of some treatment on some outcome), most social research involves both inductive and deductive reasoning processes at some time in the project. Even in the most constrained experiment, the researchers may observe patterns in the data that lead them to develop new theories’ (Trochim 2002).

5.3 Methodology: The Great Divide

Much of the literature on research methodologies identifies a fundamental divide involving the association of the objectivist approach with ‘middle range theory’ (Merton 1957) deductive reasoning and quantitative research methods and the constructionist approach with ‘grounded theory’ (Glaser and Strauss 1967) inductive reasoning and qualitative methodologies. Grounded theory thus involves the construction of theory as it emerges from the data whilst middle range theory is concerned with the testing of established hypothesis.

Layder (1993) has argued that the traditional polarisation of these two approaches has been to the detriment of social theory. Middle range theory has typically been associated with the macro social world, while the grounded theory approach has concentrated on micro relations. The traditional separation of macro and micro level research has meant that links between the two levels have been difficult to make. Layder advocates a ‘realist’ approach to social research which can incorporate both a macro and micro view of the social world.

Giddens (1993) further questions the utility of traditional divisions in social theory:

‘..the distinction between micro and macro analysis is not a very useful one in social science, at least in some of the ways in which it is ordinarily understood. It is especially misleading if seen itself as a dualism – where ‘micro situations’ are those to which a notion of agency is appropriate, whereas ‘macro-situations are those over which individuals have no control. What is important

is to consider the ties, as well as the disjunctions, between situations of co-presence and 'mediated connections' between individuals and collectivities of various types' (Giddens 1993:7).

The approach taken in the present study was to adopt a semi-structured interview technique to access the micro world of clinician and managers' views of the management role. This approach is supported by the primary collection of 'macro' nation-wide data on the background, gender and current rewards of practice managers, contrasted with secondary analysis of existing cross sector data. Quantitative data has informed qualitative data collection and vice-versa. As Layder notes:

'Theory can emerge out of the intersecting influences of quantitative and qualitative data. The two types of data can continually feed into one another in a complementary sense' (Layder 1993:120).

Indeed contrary to much of the literature on methods and research paradigms, the quantitative postal survey raised unanticipated issues which changed the future direction of the research, as Bryman notes:

'Quantitative research is often much more exploratory and unpredictable in outcome than its description by the advocates of qualitative research seems to imply (Bryman 1988 :97).

Crotty notes, 'the great divide' is more appropriately sited at the level of epistemology and not, as so much of the literature posits, at the level of methods. Thus there is a fundamental difference between the constructionist and objectivist approach to knowledge, which cannot be reconciled. One cannot accept that there is an 'objective truth' waiting to be 'discovered' whilst also believing that truth and meaning are socially constructed. However there is no inevitable connection between objectivist epistemologies and quantitative research methods and constructionist approaches with qualitative techniques: counting is not inherently positivist (Crotty 1998).

Bryman notes:

‘If one is looking at the social structural determinants of people’s behaviour and views at the macro-level, then designs using large-scale surveys are appropriate. But if one is looking at the way people respond to these external realities at the micro level, accommodating them to the inevitable, re-defining the situation until it is acceptable or comfortable, kicking against constraints or fighting to break out of them, or even to change them. Then qualitative research is necessary. If surveys offer the bird’s eye view, qualitative research offers the worm’s eye view’ (Bryman 1988: 28).

5.4 Triangulation and Methodological Pluralism

Growing interest in bridging the ‘great-divide’ at the level of research method, and recognition of the benefits of multi-method studies has led to increased use of the term ‘triangulation’ in social research.

Defined by Bryman as:

‘...the use of more than one approach to the investigation of a research question in order to enhance confidence in the ensuing findings’ (Bryman: unpublished).

As Bryman notes, triangulation is an over-used term, applied to any study in which two or more methods are involved. Bryman draws a distinction in the correct use of the term ‘triangulation’ as relating to:

‘...specific occasions in which researchers seek to check the VALIDITY of their findings by cross-checking them with another method’ (Bryman: unpublished. Original emphasis).

The present methodology applied a number of methods to gain a holistic analysis of management in general practice, implementing:

- Quantitative techniques to obtain a picture of the profile and rewards of managers across England and Wales
- Depth interviews with managers and clinicians to investigate meanings, perceptions and experience of management roles
- Analysis of policy documents to distinguish the external pressures and influences on clinicians and managers regarding the management of health care resources.

This approach is most accurately described as ‘methodological pluralism’, defined by Olsen as:

‘.....a pluralism of method that enables the researcher to use different techniques to get access to different facets of the same social phenomenon’ (Olsen, 2004:6).

Olsen uses the example of studies of social class to illustrate the pluralist approach:

‘For social class studies for instance, a methodological pluralist would examine qualitative data on how it feels to be working class; quantitative data on the flows of resources between classes or their asset base; and policy documents in order to see how policies interact with or define social classes’ (2004:6).

In much the same way this study has used a quantitative survey to ascertain occupational profile and rewards, qualitative interviews to investigate meanings and experience of what it is to be a manager/clinician in general practice and analysis of policy documents to assess how external directives have impinged upon and attempted to define the role of management in primary care.

Rather than acting as a 'check' and 'validation' of data produced from differing methodologies, the pluralism of methods employed in this study aimed to address the differing facets of the research question, recognising the complexity and diversity of social life and the multiple sites and forms of power.

The resulting strength of the study is its ability to provide a holistic, multi-disciplinary analysis that could not have been achieved by the application of a single research method.

The remainder of this chapter focuses on the implementation of the research, ethical issues encountered and an assessment of how methodologies could be improved.

5.5 Ethics and Social Research

'Research ethics' refers to the 'moral principles guiding research, from its inception through to completion and publication of results and beyond' (ESRC 2005: 7).

The Economic and Social Research Council identify six key principles of ethical research:

- Research should be designed, reviewed and undertaken to ensure integrity and quality
- Research staff and subjects must be informed fully about the purpose, methods and intended possible uses of the research, what their participation in the research entails and what risks, if any, are involved
- The confidentiality of information supplied by research subjects and the anonymity of respondents must be respected
- Research participants must participate in a voluntary way, free from any coercion

- Harm to research participants must be avoided
- The independence of research must be clear, and any conflicts of interest or partiality must be explicit (ESRC, 2005: 1).

Many ethical issues were raised in the process of this research from ensuring that sampling strategies provided a robust basis for extrapolating survey findings to the wider population base, to the interpersonal dynamics and power relations experienced in one to one interviews with clinicians and managers. These issues are raised where appropriate in the following overview of research methods.

5.6 Research Methods

As previously noted, three methods have been employed in the delivery of this research including a large-scale postal survey, depth one to one interviews and secondary data analysis.

5.6.1 Secondary Data Analysis

Labour market statistics, themselves the product of cultural constructions of what it means 'to work', are a rich and valuable source of data for the analysis of 'lived relations' of gender and class. Based on large-scale surveys of the labour force and attempting to apply consistent definitions over time, such statistics are able to demonstrate the changing nature of employment and its rewards. It is analysis at this level which reveals persistent and widespread inequalities in the labour market. Chapter four provided an overview of the labour market sourced principally from National surveys implemented by the Office for National Statistics.

Other secondary data sources used in the thesis have included original extracts from Hansard, recording exchanges taking place in the House of Commons during periods of change in health care policy, and published policy documents.

5.6.2 Postal Survey

The first stage of primary fieldwork was conducted during the period September 1994 to June 1995 and consisted of a postal survey of 750 practices across England and Wales.

Sampling

The total population of GP practices was 9645 in 1994 (Royal College of General Practitioners 1999). The project aimed to achieve a confidence interval of 5 at the 95% confidence level, that is to say had all practices been surveyed actual results would lie within plus or minus 5% of survey findings. This is a standard commonly adopted in the research industry and requiring a minimum achieved sample of 370 completions.

The sample was drawn in two stages. At the first stage 33 FHSAs were randomly selected from an alphabetical list of 98 FHSAs in England and Wales in 1993. Each of the selected FHSAs was asked to provide a list of general practices and 23 (70%) did so.

The size of the practice was anticipated as a key variable in the research since it is linked to increasing complexity of organisational structure and fund-holding status (initially the scheme was only open to larger practices). Practices were thus stratified into four size bands⁵. A total of 750 practices were then randomly selected with sampling fractions varying by size band⁶. The final sample consisted of 86 practices in Band 1, 102 practices in Band 2, 388 practices in Band 3 and 174 practices in Band 4.

⁵ Band 1 = practices with one partner, Band 2 = practices with two or three partners, Band 3 = practices with four or five partners and Band 4 = practices with six or more partners.

⁶ Ranging from 1 in 9 in Band 1 to 1 in 2 in Bands 3 and 4.

A postal questionnaire was sent to the practice manager in each practice (document shown at appendix one). Reminders were mailed to non-respondents after three weeks and again after a further three weeks. The questionnaire consisted of three sections. Section one asked for details of the person completing the schedule (i.e. the practice manager in all but a few practices): their background, tenure, salary, and training. Section two contained questions about the practice: its size, fundholding status, numbers and ages of the partners, and numbers and employment status of other staff (clinical and non clinical). Section three sought details of how the practice dealt with a range of hypothetical staffing matters exploring allocation of authority, formality of policies and flexibility of roles. Data from section three was mainly used in publications relating to the wider project on human resource management and is not heavily drawn upon in this thesis.

An accompanying cover letter explained the purposes and ownership of the research and guaranteed the anonymity of all survey respondents in data reporting. The study therefore met ethical requirements to ensure respondents are fully informed of research objectives, ownership and risks, participate freely in the research process and remain anonymous in research outputs.

Response Rate

Replies were received from a total of 477 (64%) practices. The response rate ranged from 74% in the largest (Band 4) practices to 43% in the smallest (Band 1) practices. Both the achieved sample size and spread of response across the target survey population provides a high level of confidence in survey results.

Owing to resource constraints no further follow-up of reasons for non-response was undertaken. It is likely that reasons included workload pressures, database error (inaccurate address/contact information) absence of a designated Practice Manager role within the practice and a preference not to take part in/share information regarding the subject of the survey. Of these, the latter two reasons are most likely to have a potential impact on the end results. Unfortunately it is not possible to

determine the contribution of these two factors to overall non-response: a factor that could be improved upon in future work.

Statistical analysis of the data was performed using the SPSS package. All statistics from the postal survey referred to in the thesis have been derived from the X test with a 95% confidence interval.

5.6.3 Semi-Structured Interviews

The second phase of research involved delivery of depth interviews with managers and clinicians. The aim of this phase was to provide more detailed exploration, rather than quantification, of the trends and themes emerging from the postal survey. The key to the success of this phase was therefore the achievement of a diverse sample of participating managers and practices, to fully explore emerging 'typologies' (based on a mix of practice and manager characteristics).

Sampling and Response Rates

Participants in the interview survey were initially selected from volunteers recruited in the first phase of fieldwork. A question was inserted in order to measure interest in continued participation. Two fifths of all managers surveyed (41%) expressed interest in continuing their participation in the survey, totalling 196 managers. Those respondents expressing an interest in further participation were issued a letter explaining that this would involve a visit to the practice and an interview with themselves and a partner. Involving a time commitment of between one and two hours plus access to a General Practitioner, this invitation reduced the number of managers willing to participate from 196 to 26.

Again it was not possible to determine precise reasons for non-response but it is likely that reasons included time pressure, unwillingness to commit GP resource and/or a preference not to take part in/share information regarding the subject of the survey. In addition fear of the research process and lack of personal confidence may have been factors in the second phase given that contact was in the form of a face to

face interview. No pressure was brought to bear on individual parties to participate in the research.

All managers expressing a willingness to participate were included in the second phase, involving interviews across England. Analysis of the profile of practices and managers consenting to participate indicated a disproportionate number of male managers with a private sector background based in fund-holding practices. There was a strong possibility that this profile, being atypical of the wider study population, would bias the resulting analysis of management and clinicians roles at this more detailed phase of the research.

In order to ensure that the views of female managers in smaller, non-fund-holding practices were explored it was necessary to undertake a second batch of interviews. The sample from the postal survey had been exhausted and it was necessary to approach new practices. Analysis had not indicated any geographical differences in emerging data, it was therefore determined that the second wave of interviews would be conducted within Tyne and Wear in order to reduce fieldwork costs.

Findings from postal surveys and early interviews indicated that managers in this target group were likely to be involved in locally based self-help groups. Given that postal approaches had not been successful in recruiting female managers in smaller practices it was felt that such groups would be a supportive, familiar environment in which to introduce the research. The Family Health Services Authority was approached for details of local Practice Manager Groups and these were contacted with a view to introducing the project. Arrangements were made to key into existing group meetings at which the research was introduced and new practices recruited: a further twenty-four practices were recruited via these means.

Researchers bear a responsibility to ensure the validity, integrity and quality of research undertaken, a key component of which is the removal or limitation of any consistent bias and the inclusion of all voices in the research process. This work

demonstrates that with flexibility and ingenuity, 'harder to reach groups', however they may come to be defined, can be engaged in and empowered by research when potential barriers to access are understood and addressed. In this case, the use of a familiar and supportive group environment appeared to reduce potential concerns regarding the research process, concerns that may have been a factor in lowering response to more formal written approaches.

A total of forty-one practices were included in the interview survey, involving forty-two interviews with managers and interviews with nineteen partners. As these figures indicate, it was not possible to achieve an interview with a partner in every practice. Reasons for failing to achieve a partner interview included refusal of partners to participate, refusal of the practice manager to provide access to a partner and failure to attend agreed appointments on the part of GPs following changes in workload or circumstances etc. It is further noted that the views of individual partners should not be taken to represent the partnership view, as interview data suggested partners could have radically different views and approaches towards the management of the practice both across and within partnerships.

Difficulties in accessing partner time and appraising the views of all clinicians within the practice highlight the drawbacks of the interview approach. Given the lack of detailed investigation available at phase one (postal survey) it was necessary to build a greater knowledge of all potential experiences or 'typologies' by undertaking a relatively large number of depth interviews at phase two. This spread of resource constrained the time available to each practice, limiting the number of people that could be interviewed and negating the possibility of observational methods to triangulate reported and actual practice in management approach.

This and future studies could be enhanced by a third stage involving selection of small number of case study sites where field-work can take place over a prolonged period and involve all members of the practice team. This is particularly pertinent when considering some of the findings of this work outlined at chapters six and

seven, where the independence and difference in approach of singular partners is highlighted.

Delivery of Interviews

Interviews adopted a semi-structured format guided by an 'aide memoire' (Burgess 1984:108) identifying key areas to be addressed in all interviews. As noted, question areas included the previous work history, training and current role of managers, and partner's views of the management role and their involvement in the management of the practice. Interviews did not adopt a 'fixed' question ordering with significant variance in the depth to which issues were covered in each interview, led by the respondent's interests and focus (interview guide supplied at appendix one).

Jones (1985) emphasizes the benefits of such an approach as being the ability to directly question and explore, not available to an 'observer', whilst also avoiding the constraints imposed on respondents by more structured techniques:

'To understand other persons' constructions of reality we would do well to ask them (rather than assume we can know merely by observing their over behaviour) and to ask them in such a way that they can tell us in their terms (rather than those imposed rigidly and a priori by others) and in a depth which addresses the rich content that is the substance of their meanings (rather than through isolated fragments squeezed onto a few lines of paper)' (Jones 1985:46).

Rather than enabling the interviewee to introduce their agenda to the research process, some have viewed the flexibility of semi-structured interviewing as laying open the potential for interviewer bias:

'Informal interviewing gives much greater scope to the personal influence and bias of the interviewer than the formal approach, the investigator at least partly determines what form the interview takes, the questions that are asked and the details that are recorded' (Moser and Kalton 1993:299).

We are informed:

‘The interview is not simply a conversation. It is rather a pseudo conversation. In order to be successful, it must have all the warmth and personality exchange of a conversation with the clarity and guidelines of scientific searching. Consequently, the interviewer cannot merely lose himself in being friendly.....He is a professional researcher in this situation and he must demand and obtain respect for the task that he is trying to perform (Benney and Hughes in Oakley 1980:309).

In commenting on this position Oakley observes:

‘Every interview is the practice that challenges this theory, for the important questions are: does the theory work, should it be made to work? Is this the best way to get inside people’s experiences, to make available to others the private meaning of being human?’ (Oakley 1980:310)

As Oakley found in her research on motherhood (1980), a large gap exists between ‘textbook ‘recipes’ for interviewing and practical experience in the field. A number of ethical dilemmas were encountered in the delivery of depth interviews including the necessity to withhold information from respondents to protect the anonymity of the wider sample and maintain the integrity of the research process. Many respondents asked for information relating to how others had answered questions, particularly with regard to managers financial rewards and working relationships with clinicians.

Some respondents also sought the interviewers personal opinion and experience in a ‘trade’ of information and sharing of experience. Methods texts (e.g. Moser and Kalton 1979, De Vaus 2001) warn against the dangers of introducing bias by answering respondent’s queries and offering personal information. Goode (1952) advises that when a respondent asks for your opinion:

‘A few simple phrases will shift the emphasis back to the respondent. Some which have been fairly successful are ‘I guess I haven’t thought enough about it to give a good answer right now’...sometimes the diversion can be a head shaking gesture which suggests ‘that is a hard one’ (1952:198).

The 'coping' strategy adopted in this study was to give information at the end of the interview (in general terms and without revealing the identity of comparator cases).

Reactivity to factors outside the authors control was also evident however, as exemplified in the following reference to gender, in a discussion about the approach of male and female managers with a male partner:

'I guess a lot of men have been brought in as part of the practice's concept that "We are going in the new way now, we will try this" and whether or not they actually do it any better I don't know I mean, it doesn't worry, our PM didn't come from within the ranks she came from outside, I would wonder about the people management but I honestly can't think that if you have got the right person it would make a huge difference But I have no idea whether that would be true or not. It's a bit like saying how would a male Doctor get on with a female patient, well there must be some difference but on the other hand you manage. There are some portions of women's problems that you address and presumably there are some that you don't. You are a woman yourself so I guess that the analogy would be the same' (1377 Male Partner).

The physical presence of the author's gender, age and ethnicity, to name but a few characteristics, undoubtedly influenced the interaction which took place in the interview context, factors that are not physically 'on display' in the postal survey instrument. Whilst the above example clearly draws reference to gender, there was a less tangible but nonetheless commonly felt sense that in some exchanges, the author's youth and junior occupational status served to reduce barriers and inhibitions which may have been encountered by a more senior investigator, or one with a differing occupational role i.e. the author was less likely to present a 'threat' to the status or authority of the interviewee.

In common with Oakley it is concluded that:

'Contrary to what the text books say, researching and being researched are parts of human interaction; it may be wishful thinking (or unnecessary pessimism) to think that they can be governed entirely by 'scientific' principles' (Oakley 1980:310).

5.7 Qualitative Analysis

Interviews were taped and fully transcribed in order to retain as much interview content and context as possible. There were a number of advantages of this approach including the ability to focus entirely on the interviewee and future question areas as opposed to note taking, no selection or bias in data recording, the production of a full and permanent record of the interview process and the retention of voice intonation and emphasis in audio records.

Awareness and reactivity to the tape recorder is the main disadvantage in this technique and ethical issues are raised where the respondent is intimidated or made uncomfortable by the presence of a taping device. Permission was sought from all respondents prior to recording and most spoke freely without any regard for the tape recorder. However in one or two cases where there appeared to be reluctance to discuss an issue on tape, turning off the device immediately re-opened the conversation.

Taped interviews were fully transcribed, which although time consuming, produced a rich and detailed data source. The transcription and data preparation process also served to re-familiarise the author with interview content, enabling themes to be developed as the fieldwork progressed.

A range of approaches to the analysis of qualitative data are documented in methods literature (e.g. Miles and Huberman 1994, Taylor and Bogdan 1984) with no identified 'best practice' being clearly discernable:

'When we talk about.... the analysis of qualitative data we are not dealing with a monolithic concept like statistics. No one has 'codified' the procedures of qualitative analysis, and it is not likely that anyone ever will' (Tesch 1990:4).

The following section provides an overview of the process adopted in this work

5.7.1 Coding of Interview Transcripts

Broad themes were developed from interview transcripts in order to group data on common subject areas together. Thus comments on the comparison between male and female approaches to the management task were grouped under the broad field code of 'gender', discussion regarding the management of clinical work were grouped under 'profession'. Broad coding groups were therefore developed from the reading and marking of hard copy transcripts, which totalled in excess of 1000 pages. Coding was primarily implemented as a means of 'signposting' (Becker and Geer 1960), enabling passages relating to a common subject area to be drawn together for further comparison and analysis. In order to assist in the further exploration of data, transcripts were prepared for use with NUD.IST software.

5.7.2 The use of computers in qualitative analyses

Nudist stands for Non-numerical Unstructured Data Indexing and Theorizing and is a computer package to assist in the coding, search and exploring text data from sources such as interview transcripts and/or field documents.

Developed over the last two decades, such programmes have built upon the basic text retrieval functions of word processing packages to offer sophisticated tools for the analysis of text data. Their introduction has been met with a mixed response from academics as Fielding notes:

'Many qualitative researchers believe that the use of software poses a threat to the craft skills of a long-established research tradition. There is a perceived danger of superficial analysis produced by slavishly following a mechanical set of procedures' (Fielding 1993:2).

Further, the use of such tools is seen as inimical to the concept of *Verstehen* which emphasizes the ambiguity and context-relatedness of everyday language use. Thus it is argued that the 'tacit knowledge' developed by the researcher in the field, cannot be formalised and processed using algorithmic procedures as quantitative data are

analysed using statistical algorithms (Kelle 1997). Such packages, it is argued, distance the researcher from their data and enforce analysis strategies that go against the methodological and theoretical orientations of qualitative research (Siedel 1991).

The potential risk of detachment from context is certainly laid open in the use of such packages, with capacities to search for text strings and quantify occurrences of particular words inviting the analyst to fragment data and interpret text units in isolation. However, the author is in agreement with Kelle in his conclusion that:

‘Nevertheless, these arguments only relate to the possibility of analysing textual data with the help of algorithmic procedures (like quantitative data are analysed with the help of statistical algorithms), but not to the opportunities of ordering and structuring textual material with the help of database technology’ (Kelle 1997:para 1.4).

Used appropriately, such programmes offer considerable benefit in the analysis of qualitative data, enabling greater comparison and interrogation of data than could be achieved by hard-copy coding.

The coding structure developed for this project comprised of two branches: content and characteristics. The former grouped transcript output into broad subjects, the latter identified respondent and organisation characteristics including role, gender, previous post, size of practice and fund-holding status. Tables of these characteristics are supplied for reference (see tables 5.1 and 5.2).

The programme offers a number of set-up options, including the structure of text units which can be defined as paragraphs or lines of data. In order to ensure that retrieved codes maintained the surrounding context as much as possible, text units were defined as paragraphs and codes were applied one paragraph above and below the text unit in which the code occurred. Full copies of the transcripts are also stored in the programme and these were frequently referred to where retrieved units did not provide sufficient context for interpretation.

Search and retrieval was primarily undertaken using index as opposed to string searches. Thus in order to compare the views of male and female managers on gender and management, a search would be undertaken to include all documents coded gender 'female' and role 'manager', intersected with comments coded 'gender', swiftly producing a report on all comments relating to gender made by female managers. This process would then be repeated for male managers. Hard copy reports would then be compared manually. Further use of the software could be employed to compare the views of female managers with a private sector background etc. enabling continual refinement of analysis.

Thus the package was used as a means of organising and retrieving data and not as a 'theory building tool' in itself. The latter process remained to be the product of analytical thought and interpretation on the part of the researcher, a process that can never be thoroughly documented.

Finally it is important to note that as the sole researcher (under the direction of the supervisory team) I held the ultimate power to determine how the collected thoughts, views and experiences reported by managers and clinicians were interpreted and communicated: an ethical issue that is not easy to resolve in the research process. With greater time, resources and reflective experience it may have been feasible to lessen this imbalance by offering participants the opportunity to comment on interview notes and draft analyses.

Table 5-1: Profile of managers interviewed

Practice	Title	Fund holding	Practice size	Sex	Salary	Previous Post	Management Level
48	General Manager	Yes	Large	Male	£26,000 plus	Armed forces	Senior
52	Practice Manager	Yes	Medium	Female	£16,000 to £20,999	Private sector non-management	Middle
58	Practice Manager	No	Medium	Female	£10,000 to £15,999	This practice	Supervisory
364	Practice Manager	Yes	Medium	Male	£21,000 to £25,999	Private sector management	Middle
384	Practice Manager	Yes	Large	Male	£21,000 to £25,999	Accountant	Middle
386	Practice Manager	Yes	Large	Female	£21,000 to £25,999	Other practice	Middle to Senior
394	Practice Manager	No	Medium	Female	£21,000 to £25,999	Practice Manager other practice	Middle
395	Practice Manager	Yes	Large	Female	£16,000 to £20,999	This practice	Supervisory to middle
449	Practice Manager	Yes	Large	Female	Refused	Other practice	Middle
449	General Manager	Yes	Large	Male	£26,000 plus	Accountant	Senior
487	General Manager	Yes	Medium	Male	£16,000 to £20,999	Private sector management	Middle
489	Practice Manager	Yes	Medium	Female	£10,000 to £15,999	PM other practice	Middle
523	Practice Manager	No	Small	Female	£10,000 to £15,999	This practice	Supervisory
529	Practice Manager	No	Medium	Female	£10,000 to £15,999	Private sector management	Middle
1077	Practice Manager	No	Medium	Male	£21,000 to £25,999	Armed Forces	Middle
1087	Practice Manager	No	Small	Female	£8,000 to £9,999	This Practice	Supervisory to middle
1089	Practice Manager	Yes	Medium	Male	£26,000 plus	Armed Forces	Middle to Senior
1101	Practice Manager	No	Large	Male	£26,000 plus	Armed Forces	Middle
1244	Practice Manager	No	Small	Female	£8,000 to £9,999	This practice	Supervisory
1252	Practice Manager	Yes	Medium	Male	£21,000 to £25,999	Armed Forces	Middle to Senior
1254	Practice Manager	Yes	Large	Male	£26,000 plus	Accountant	Middle
1262	Practice Manager	Yes	Medium	Male	£21,000 to £25,999	Accountant	Middle to Senior
1295	Practice Manager	Yes	Large	Female	£10,000 to £15,999	Public sector management	Senior
1323	Practice Manager	No	Small	Female	£10,000 to £15,999	Full time house manager	Middle to Senior
1352	Practice Manager	Yes	Medium	Female	£16,000 to £20,999	Other Practice	Senior
1361	Practice Manager	Yes	Medium	Female	£16,000 to £20,999	Practice Manager other practice	Senior
1369	Practice Manager	Yes	Large	Female	£16,000 to £20,999	Practice Manager other practice	Middle
1372	Practice Manager	No	Medium	Female	£21,000 to £25,999	This practice	Supervisory to middle
1376	Practice Manager	Yes	Large	Female	£16,000 to £20,999	This practice	Middle
1377	Practice Manager	Yes	Large	Female	£21,000 to £25,999	Banking	Middle to Senior
1382	Practice Manager	Yes	Medium	Female	Refused	Practice Manager other practice	Middle
1398	Practice Manager	Yes	Large	Female	£21,000 to £25,999	Public sector management	Senior
1455	Practice and Fund Manager	Yes	Medium	Male	£26,000 plus	Banking	Middle
1459	Practice Manager	No	Large	Female	£8,000 to £9,999	This practice	Supervisory
1461	Practice Manager	Yes	Large	Female	£21,000 to £25,999	This Practice	Middle
1521	Practice Manager	Yes	Medium	Female	£21,000 to £25,999	Other Practice	Middle
1522	Practice Manager	No	Small	Female	£10,000 to £15,999	Other practice	Supervisory
1525	Practice Manager	No	Small	Female	£10,000 to £15,999	This practice	Supervisory
1527	Practice Manager	No	Small	Female	£10,000 to £15,999	Public sector non-management	Supervisory
1528	Practice Manager	No	Small	Female	£10,000 to £15,999	This practice	Supervisory
1530	Practice Manager	No	Small	Female	Refused	This practice	Senior

Table 5-2: Profile of General Practitioners interviewed

Practice	Role	Fund Holding	Size	Gender	Type
52	General Practitioner	Yes	Medium	Male	Transitional
394	General Practitioner	No	Medium	Male	Transitional
487	General Practitioner (1)	Yes	Medium	Male	Transitional
487	General Practitioner (2)	Yes	Medium	Male	Transitional
489	General Practitioner	Yes	Medium	Male	Transitional
523	General Practitioner	No	Small	Female	Traditional
1087	General Practitioner	No	Small	Male	Traditional
1254	General Practitioner	Yes	Large	Male	Transitional
1262	General Practitioner	Yes	Medium	Male	Transitional
1352	General Practitioner	Yes	Medium	Male	Transitional
1361	General Practitioner	Yes	Medium	Male	Progressive
1369	General Practitioner	Yes	Large	Male	Transitional
1376	General Practitioner	Yes	Large	Male	Transitional
1377	General Practitioner	Yes	Large	Male	Transitional
1382	General Practitioner	Yes	Medium	Female	Transitional
1384	General Practitioner	Yes	Medium	Female	Transitional
1461	General Practitioner	Yes	Large	Female	Transitional
1527	General Practitioner	No	Small	Male	Traditional
1528	General Practitioner	No	Small	Female	Traditional

CONCLUSIONS

Research is not a clinical act conducted under perfect circumstances. Indeed, it is as much the product of providence and circumstance as planning and theoretical purity. Whilst there are inevitably areas where the research programme could be enhanced and improved, this chapter has demonstrated that the approach adopted was robust and fit for purpose.

Commencing from a constructionist perspective and with the aims of embracing both macro and micro levels of analysis, the pluralist methodology adopted has provided a holistic analysis of management in general medical practice.

A representative and robust picture of the 'lived relations' of gender and rewards within the occupation of practice management has been provided, enhanced with a detailed and rich analysis of the 'meanings that working people impute to such lived relations and utilize to transform them' (Bradley 1999:10). The latter being explored via depth interviews with managers and clinicians.

Secondary analysis and review of the process of policy development and the introduction of changes in health policy in the late eighties and early 1990s has provided a further piece in the jigsaw, enabling us to better understand the complex dynamics and relationships between genders, occupations and the State.

The main drawback to the approach adopted is the lack of a complete picture for any singular organisation. Difficulty in interviewing partners has been noted and very few practices provided access to more than one partner: where this occurred the tensions and struggle between partners was revealed adding a further dimension to the understanding of primary care organisations. Furthermore, interview based fieldwork must inevitably rely on the self-reported views of respondents themselves, which although key to an understanding of the organisation, could perhaps be beneficially supported by other methods such as observation.

Thus whilst the study has provided a valuable and robust insight in to the changing nature of primary care organisations and the roles of clinicians and practice managers within them, it is noted that a third phase involving a case study approach, may have served to further illuminate the dynamics revealed by this work.

The following chapters will provide a detailed analysis of quantitative and qualitative data collected in the process of this study, drawing out managers' and GPs' views of the management function in general practice, managerial influence on the organisation and control of clinical work and the gendering of the practice manager role.

CHAPTER SIX

PRACTICE MANAGEMENT IN THE 1990s

INTRODUCTION

This chapter presents findings from quantitative and qualitative fieldwork in drawing out managers' and clinicians' views on the roles, functions and implementation of management in the practice. Commencing with a profile of Practice Managers employed in practices across England and Wales, the chapter moves on to explore the daily experience of management in more detail.

Names have been changed in order to protect the anonymity of respondents. The role and gender of the respondent are noted in brackets following speech quotation, alongside a reference number for the practice. The author's speech is presented in bold type.

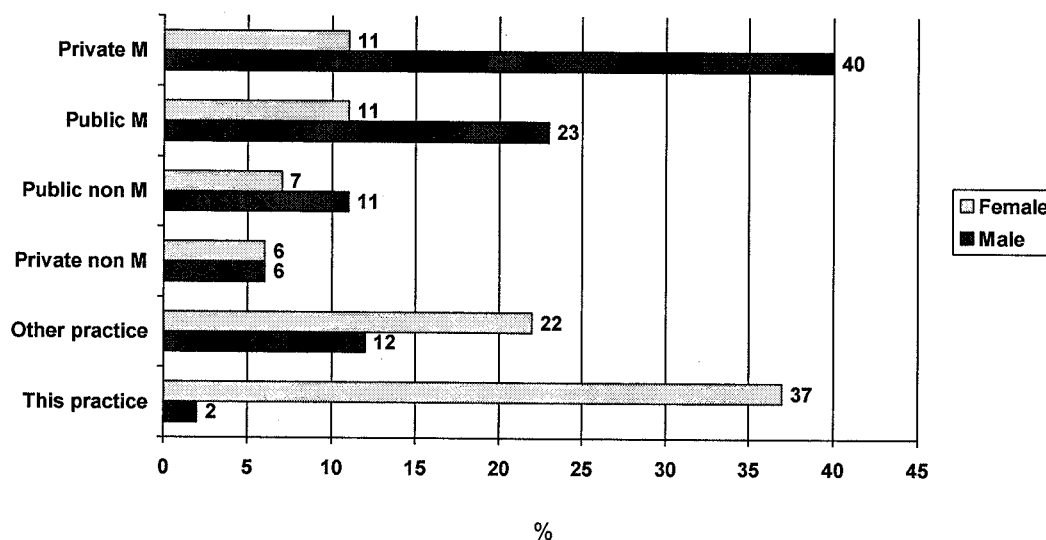
6.1 Profile of Practice Managers

This profile has been sourced from a postal survey of 477 practices in England and Wales. The vast majority of Managers (86%) were female with three-quarters being aged between 40 and 59 (77%). Hours of work for the majority (52%) were between 30 and 39 hours per week but a large proportion (35%) worked between 40 and 49 hours.

More than half of all male managers (55%) had been in post for two years or less at the time of the survey compared with almost one quarter of female managers (23%). A large proportion of female managers had been in post for a significant number of years with 24% being in post for between six and ten years and a further 18% being in post for eleven years or more. This data therefore confirms observations that the entry of men into practice management largely commenced with the change in the GP contract and GP fund holding.

Analysis of the previous career history of managers again showed significant differences between male and female managers.

Figure 6-1: Previous post of Practice Managers



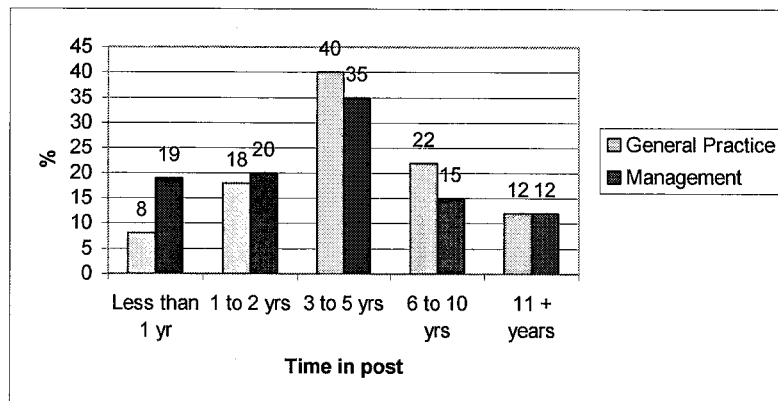
M = management

The majority of male managers recruited to general practice came from public (23%) or private sector management backgrounds, with a further 17% coming from non-management public and private sector posts. Female managers were significantly more likely to be recruited from within general practice at 59% of all female managers compared with 14% of male managers. Of these, over one third of female managers were promoted from within the same practice (37%) compared with one male manager. Less than one quarter of all female managers (22%) were recruited from management posts in the public (11%) or private sector (11%).

Whilst the entry of males with careers in management may have been a relatively recent introduction in general practice, the existence of practice managers with a management background is not. Figure 6.2 shows the length of time in post for managers recruited from within general practice and those whose previous post was in public or private sector management. The distribution is extremely similar with both 12% of managers recruited from within general practice and 12% of managers

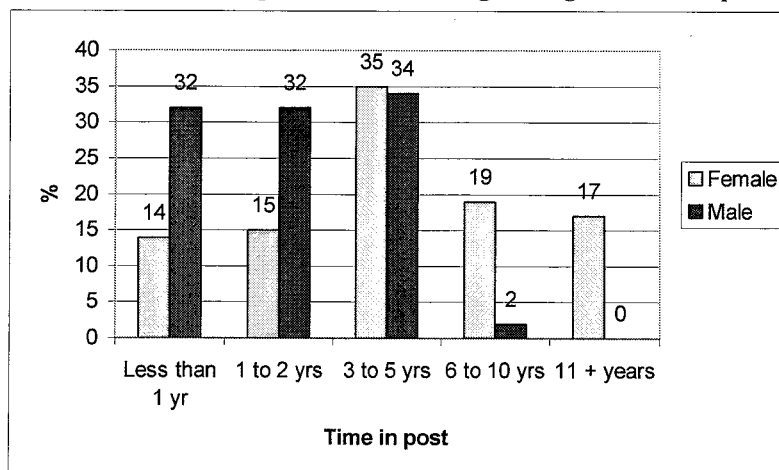
with private or public sector management experience being in post for eleven years or more. The figures for those in post for 6 to 10 years were 22% and 15% respectively.

Figure 6-2: Length of time in post



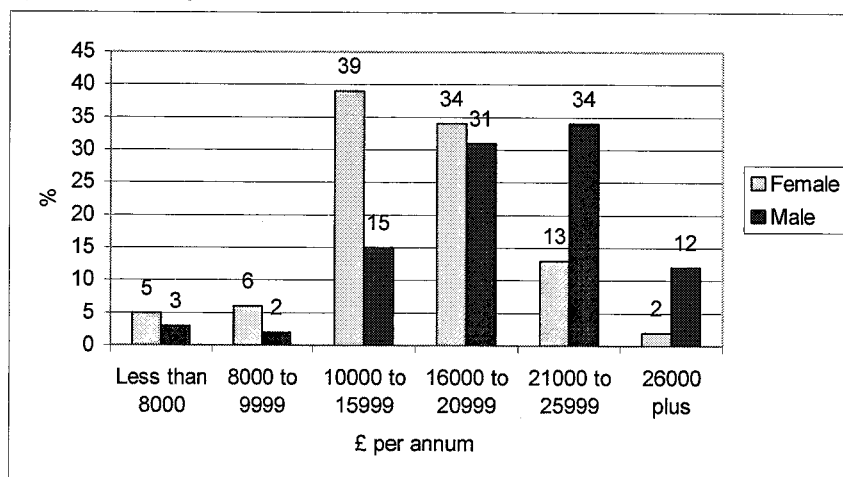
When analysed further it would appear that women with management backgrounds were entering general practice far earlier than their male counterparts. Figure nine compares the length of time in post for male and female managers with public and private sector management backgrounds. Over one third of female managers (36%) had been in post for six years or longer compared with 2% of male managers.

Figure 6-3: Public and private sector managers length of time in post by gender



Managers' salaries ranged from £8,000 to in excess of £26,000 per annum. Analysis by sex indicated that male managers earned significantly higher salaries than female managers, with 12% of male managers earning more than £26,000 per annum compared with 2% of female managers. Just over one third of male managers (34%) earned between £21,000 and £25,999 per annum compared with 13% of female managers.

Figure 6-4: Salary

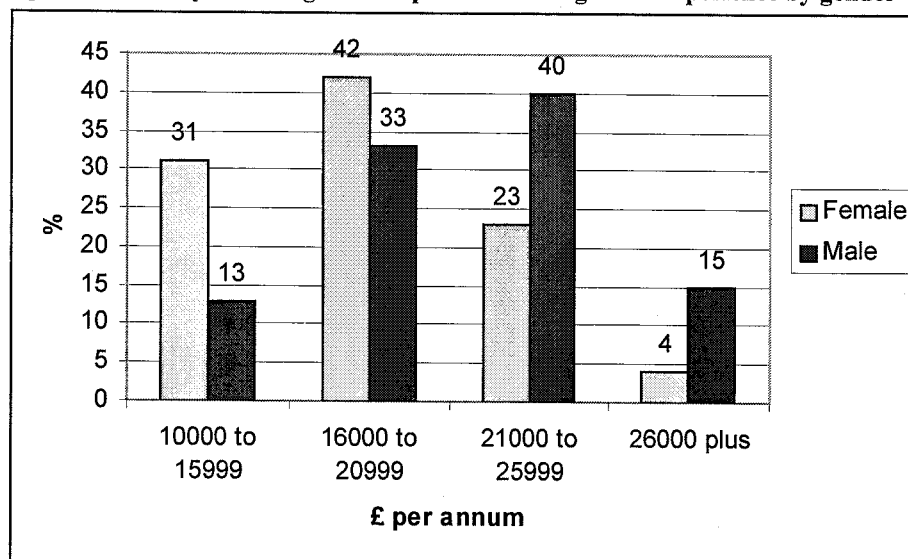


Salary is linked to the fund-holding status of the practice since this initiative brought with it an increased management allowance. Almost one third (30%) of fund holding practices paid salaries of £26,000 or more compared with 7% of non-fund holding practices. Male managers were more likely (54%) to be employed in fund holding practices than female managers (37%). This does not, however, explain the salary differential. Looking only at those managers employed in non-fund holding practices, 23% (n=7) of male managers earned £21,000 or more per annum compared with 6% (n = 14) of female managers.

Previous career history may be expected to have a link to the salary attracted by individual managers. However, once again, this does not explain the salary differentials experienced by male and female practice managers in general practice. Looking only at those managers with previous careers in public and private sector

management, 55% of male managers earned £21,000 or more per annum compared with 27% of female managers, with male managers being more than three times as likely as female managers to be in the highest income bracket.

Figure 6-5: Salary of managers with previous management experience by gender



This summary of practice managers' background and rewards has therefore demonstrated that older females recruited from within the ranks of general practice principally staff this occupation.

The existence of managers with public and private sector management experience is not a recent phenomenon in general practice however, with the majority of early entrants with such experience being female. This work has confirmed that, whilst a small number of male managers existed prior to the 1990 contract and introduction of GP fund holding, the entrance of the majority of male managers coincides with the introduction of the afore-mentioned policy changes.

Consistent inequality has been demonstrated in respect of the differentials in earnings of male and female managers which cannot be explained by previous career history or the greater management allowance made available to fund-holding

practices. This data is corroborated by qualitative interviews with managers (see chapter eight).

6.2 What Do Practice Managers Do? The Views of Managers

This section draws on data from qualitative interviews with Practice Managers in which interviewees were asked to describe their role and functions within the practice.

Table 6.1 compares the profile of participants in phases one and two of the research. As the second phase of work aimed at exploring the diversity of roles within practices it was important to ensure that a range of practices be contacted rather than achieving a sample profile which was representative of the actual population distribution. The resulting sample therefore achieved a greater proportion of higher earning, male managers in fund-holding practices.

Table 6-1: Comparison of samples achieved in phase one and phase two fieldwork

	Phase 1	Phase 2
Practice Size		
Large	30%	37%
Medium	47%	42%
Small	23%	22%
Fund holding Status		
Yes	39%	58%
No	60%	42%
Salary band		
1	5%	7%
2	36%	24%
3	34%	18%
4	16%	32%
5	4%	16%
Sex		
Male	14%	32%
Female	86%	68%

The following analysis presents Managers' perceptions of their role as described in a series of qualitative interviews in practices across England. In order to improve the clarity of analysis, managers' descriptions have been classified into a three-category typology. The focus of the typology is on the level of management in evidence with three categories being drawn from common management structures found in the private sector as follows:

Supervisory Management: Managers are directly involved in the daily supervision of staff and administration of budgets with limited authority to make independent decisions beyond the daily supervision of tasks.

Middle Management: Managers have the authority to implement tactical strategies to achieve policy objectives within their designated areas of authority. More senior personnel in the organisation largely determine corporate objectives and strategic direction.

Senior Management: Managers are closely involved in determining corporate objectives and strategic direction. Tactical and supervisory tasks are likely to be delegated to a supporting management or supervisory structure.

Whilst the analysis will show that this typology is not an entirely accurate reflection of the experience of management in general practice it is felt that it provides a benchmark against which the particular circumstances of general practice can be compared.

6.2.1 Senior Management

Managers operating at this level typically view themselves as being involved in overseeing the management of both financial and human resources in the practice with a significant degree of involvement in policy decisions. Such a manager is likely to be supported by other supervisory to middle management personnel who typically take on more specialised functions in relation to staff management or fund-

holding. In many cases lower management ranks include the previous 'Practice Manager'.

Managers at this level described their role as follows:

'I think I am the motivator in the practice, staff management, I handle all the financial side, I over see the computing side, and I think the biggest part of my role is taking the practice forward, planning. I spend a lot of my time producing things like, I have been working on the business plan for about three months. I am now putting together a needs analysis which has produced a number of long, medium and short term objectives, including a SWOT analysis of where we are now, what we have going for us, it has all been included in the business plan. From that I am now doing a needs analysis of what do we need in order to carry this forward, in terms of skills, time finance, from that I plan to draw a training plan for the next year. Plus a breakdown of where we are going to get the finance from and a list of all the things that need to be available' (Manager Female 1361).

'I am Group Manager, I don't administrate the practice, we have got an administrator, so I actually advise on policy. I sit on the board and I work at that level. My range of responsibilities is across everything in the practice. IT, communication, commissioning, finance, staffing. My role is to develop practice management and to devolve a lot of the duties in general practice, and to encourage an awareness from the bottom up that this is a business that needs to be managed' (Female Manager 1398).

'Is your title Practice Manager?'

'No general manager, I have an administrative manager, so we have a hierarchy. I have a reception manager who looks after all the reception staff at the moment we run two receptions. We have an administrative manager who is responsible for invoices, general sort of recruitment, personnel matters, then we have a nurse manager who is responsible for the nursing team on board, plus the link between the community nursing and ourselves. And then I have an information manager, Guy. (The previous structure) tended to be very loose and lots of stuff still came to the operations director, a direct more of a practice manager role. I changed that considerably, as my role evolved I had to drop lots of that off; I deliberately did not want to be a fund manager. I wanted to be fund and something else. I wanted the input on how health was delivered by the practice, now if I hadn't got that I wasn't interested. What I am interested in is how do we deliver health care. You need managers in general practice who are going to be talking about how do we deliver health care, not how they are going to manage the accounts the next day, how are we going to deliver health care and how will the staff play in to that. But that is my philosophy, and it is

the philosophy of the partners here. The change is I think, you have to look at it really, is before practice managers were a bit like shop floor men, and are now becoming more like the strategic Chairmen, who is looking at company strategy, and that is certainly a change in the last 18 months here' (Male Manager 48).

Seven senior level managers were identified from interviews with 40 practices, thereby indicating that this level of management was uncommon at the time of the fieldwork. Three out of the seven senior managers came from within general practice. This finding is particularly interesting given the general perception expressed during interviews, and indeed, across practice management literature, that managers 'working their way up through the ranks' within general practice are unlikely to have the broader business acumen required of management at this level. The remaining four managers came from previous careers in public sector management (2), the armed forces (1) and accountancy (1).

Two out of thirteen male managers interviewed were operating at this level (15%) closely comparing with 5 out of 27 females interviewed (19%). All managers were working within fund-holding practices with the exception of one manager who was also engaged at a senior level in work with the Association of Managers in General Practice.

The majority of managers at this level were employed in large practices with 6 or more partners (4), with two managers being employed in practices with between four and five partners. The manager with an external role with the AMGP was employed in a single-handed practice.

The salary range at this level was wide with managers' earning between £10,000 and in excess of £26,000 per annum. As in quantitative data it would appear that gender was an important factor in explaining salary variations with both managers earning above £26,000 p.a. being male.

6.2.2 Middle Manager

Middle level managers' typically describe autonomy at a tactical level in terms of implementing agreed policy and managing budgets. However at this level, managers' are unlikely to have a direct involvement in the formulation of policy and do not identify a role for themselves in determining the future direction of the practice. There is evidence of middle level managers specialising in particular management functions, supported by supervisory level staff, or less commonly other managers at the same level, who manage areas outside this specialism. Specialist roles included a focus on human resource management or fund-holding and financial management.

Typical examples of management roles at this level are shown below:

'An awful lot of my time is taken up managing situations as they arise. I look after the accountancy side of the practice myself, which is to receive the cash or whatever, link up with the accountants; I see the mail when it comes in in the mornings. I, for the past eighteen months, have been particularly involved in developing the practice leaflet and practice charter. All this has involved the development of things like filing systems; the whole nineyards of the administrative process has had to be regenerated in quite a few areas so we have a base to work from. I've taken an active part in the IT side of the business which was a task that the senior partner - relieved him of that involvement and I now look after the main computer system and the other PCs that we've got and support' (Male Manager 1077).

'I am here to manage the practice and to keep the doctors' input on the management side as hands off as I possibly can but I am not a partner in the practice, I have got no say in the decisions in the practice. Finance, my main function is finance. Not just fundholding, the whole financial aspect of the practice. We have appointed a practice administrator. Her main role is personnel. I am responsible for them all at the end of the day, everything, but the running and day to day running of the business is left very much to people such as the line managers. It is up to them if they have any problems to come to me. I probably meet with the practice administrator very regularly and the computer administrator quite regularly but the receptionist side practically runs on it's own and as long as things are OK then, I don't know anything about that side so...' (Male Manager 1254).

'As a Practice Manager and a Fund Manager you wear many hats in the course of one day. You know you have to do some very basic jobs quite honestly, as I

am the only one there on the business side of the practice. You have to sometimes do things on the maintenance around the place, or sort out problems with the plumbing and all that sort of thing, which are basic you know to try and sort them out, and then a few minutes later you can be dealing with high finance with fundholding matters so it is interesting. I don't think you can really say you spend the bulk of your time on any one thing, really, it is an extremely busy job. There is certainly no there is so little time for concentrated thought.....it is just the nature of the job. I don't think I can really say that the bulk of my week is devoted to any one thing I think it is spread over all in trying to run the practice effectively and efficiently. I have a very good office manager who has been here for 25 years and she is an extremely good girl. Very competent, she runs the team downstairs with good authority. So, hopefully the girls know I am there to help them if and when necessary' (Male Manager 1455).

Sixteen out of forty managers interviewed have been classified as middle level managers with a further six managers being identified as operating at a middle to senior level, where there may be occasional involvement at a policy level. Such involvement is likely to be on an ad-hoc basis as opposed to the main focus of the role.

Taken together, middle and middle to senior level managers account for just over half of all managers interviewed. Eleven out of thirteen male managers interviewed are classified within this group. Given the small number of respondents involved, percentage figures should be approached with caution. However at 85%, it is clear that the vast majority of male managers were operating at this level compared with 41% of female managers (11 out of 27). Given that the proportion of male and female managers at a senior level was similar, the differences are explained largely by the absence of male managers at a supervisory level.

The majority of middle managers were to be found in fund-holding practices (73%) with 27% (6) being in non-fund-holding practices. All managers at this level were employed in medium (12) or large (9) practices.

The majority of middle managers were earning between £21,000 and £25,999 p.a. (10 managers or 48%). Once again all managers earning in excess of £26,000 were

male (36% of all male middle managers). Six out of the seven middle managers earning below £ 20,999 were female (55% of all female middle managers).

The previous careers of managers at this level included general practice (8), private sector management (3), private sector non-management (1), the armed forces (4), accountancy (3) and banking (2).

6.2.3 Supervisory

Practice Managers operating at a supervisory level typically describe their role as involving the day to day 'smooth running' of the practice with a heavy involvement in routine administration and supervisory staff management. A Senior Receptionist or similar position may support the Practice Manager. Descriptions of this role are shown below:

'I usually see to the letters, post coming in, sort into things for the reception staff, and the nurses and doctors. The doctors have a box so at the end of surgery they check that. At the beginning of the week I usually get the elderly visits out and then if there are 75 years old checks to be done I get the forms ready for the doctors. Then I usually come upstairs and start work, send out 75 year old checks, cytology, smears, asking them to come in, chasing up the people and sending out results. Then accounts work, writing cheques, and then I usually get called down to reception; sometimes you have reps coming, sometimes have queries with patients' (Female Manager 1244).

'I don't deal with finances here whereas a lot of practice managers do. I don't we have an accountant and I would imagine eventually, with me doing just doing it for a year and a half I've more or less been getting all the paper side, the FHSA side, learnt and once I get through this hopefully, eventually I will get the finance side. I deal with the cheques and paying in books, I do all the basics and then every month it all goes to the accountant and he puts it into his books'.

'What would you say a typical day would involve?'

'Paperwork and opening mail that comes through at all hours of the day! Definitely paper work, I find that sometimes I can't even get out of here, I've got to go onto the counter to give a help out because I do like to work there because it keeps me in touch with what's going on, but I must admit it's sometimes the paper work' (Female Manager 1522).

‘Well finance obviously, and really administration, just literally running the day to day, obviously the girls do the filing and that kind of thing, but just making sure that everything’s on that should be and liaising with outside FHSA and MAAG I quite enjoy that sort of thing and I quite enjoy that. Having been Dr Eden’s secretary she’s very loathe to let me go from that position so I still do quite a lot of secretarial which I’m hoping to drop off now I’ve got this new girl to give me some more time to do the actual management side of it. I take a lot home because I don’t have the time or the quiet to do things’.

‘So when you say the management side, what is involved there?’

‘Well just getting systems - making sure that the personnel records are up to date - the new starter I would like to train, get her a training schedule’ (Female Manager 1528).

Eleven respondents were classified as operating at a supervisory (8) or supervisory to middle (3) level all of whom were female. All but one of these managers were employed in non-fundholding practices. The majority were found in small practices (7) although practices with between four and five partners (2) and six or more partners (2) also employed managers operating at this level. The majority of managers earned below £15,999 p.a.

Nine out of eleven managers had been promoted from within the same practice with one manager previously being employed in a different practice. One manager at this level came from a non-management, public-sector background.

Analysis will now turn to the views of clinicians regarding management of the practice and the associated roles, functions and responsibilities.

6.3 Clinicians Views on Management

Access to GPs was problematic for a number of reasons including refusal on the part of GPs, Practice Managers refusing to request partner time and appointments being cancelled due to surgeries over-running or unanticipated house calls. Where access was achieved, interviews were often time pressured, in some cases because of the above circumstances and in others because the partner was not prepared to give an hour of their time to the subject.

It is noted that interviews with individual partners are not 'representative' of the 'partnership' view since one of the main factors emerging from the interviews was the lack of a common view or agreement regarding management roles in the practice. In the majority of cases it was only possible to interview a single GP within the partnership, findings are therefore presented as the views of individual clinicians, placed within the context of practice characteristics (fund-holding status and practice size).

Interviews with clinicians explored the partners' involvement in the management of the practice and the distribution of management functions across the partnership. The role of the Practice Manager was also explored including views on the future direction of the role and involvement in the management of clinical practice.


Analysis of clinician interviews has revealed a complex interaction of factors at play in shaping individual practitioners' views of management. Figure 6.7 displays a model of GPs' views on and approach to management mapped against practice characteristics.

All partners identified a common set of management tasks within the practice including the management of staff, premises, practice finance & claims and (in fundholding practices) the management of the fund. However the interpretation of the purpose and form of 'management' differed significantly.

Analysis of qualitative interviews identified three main groupings presented by the left hand, central and far right positions within figure 6.6 overleaf. It is important to note however that the model is presented as a continuum as opposed to three closed 'types', with GPs views being positioned across the presented scale. The following analysis describes the views and approach to management within the identified categories which have been labeled as 'Traditional', 'Transitional' and 'Progressive'. The descriptors have been developed in respect of the policy agenda

to achieve a 'primary care led NHS' in which services are planned on the basis of population needs, involving proactive health management and the allocation of resources to best meet overall demands on the system. In terms of this agenda, the 'traditional' approach involves little or no change from established practice based on the support required to administer to the needs of individual practitioners delivering a service based on the individual doctor-patient consultation. 'Transitional' approaches indicate a shift towards medium to longer term planning, including the concept of 'organizational goals', however practitioners are likely to suggest that they are 'at the start' in a process of longer-term change. The 'progressive' category denotes a concerted attempt to plan on the basis of population need, with significant changes having occurred in the approach to managing the direction and resources of the practice. There is no hierarchy intended by the language used, such that progressive is 'good' or traditional is 'bad', rather the categories have been developed as a measure of the extent to which policy directives have influenced management practice.

Figure 6-6: Clinicians' models of management

	TRADITIONAL	TRANSITIONAL	PROGRESSIVE
			
PRACTICE SIZE	SMALL	MEDIUM/LARGE	MEDIUM
FUND-HOLDING	NON FUND HOLDING	FUND HOLDING	FUND HOLDING
MANAGEMENT FOCUS	ADMINISTRATIVE "Smooth running of the practice"	OPERATIONAL Manage resources effectively and efficiently	STRATEGIC "Address the health care need of the practice population"
PRACTICE MANAGER ROLE	SUPERVISORY MANAGEMENT	MIDDLE MANAGEMENT	SENIOR MANAGEMENT
PARTNERS INVOLVEMENT IN MANAGEMENT	AD HOC OR LED BY SENIOR PARTNER/ SINGLE HANDED PRACTITIONER	ROTATING FUNCTIONS	EXECUTIVE PARTNER WITH ALLOCATED ROTATING FUNCTIONS
MANAGEMENT TIME FRAME	SHORT TERM	MEDIUM TERM	LONG TERM
CASES (n)	5	13	1

6.3.1 The 'Traditional' Approach

Typically found in smaller practices, the 'traditional' view of the management function is to ensure the "Smooth running of the practice". A term frequently used, this generally encapsulates the 'supervisory' management role identified in management interviews and involving the day to day supervision of support staff, management of claims to the FHSA and 'housekeeping' associated with the practice premises. The term 'traditional' has been applied to reflect the assertion in both fieldwork and literature that this was the most common approach to practice management pre-dating the 1990 contract and introduction of fund holding.

'Traditional' clinicians are likely to retain a hands-on involvement with the management of the practice and, in particular, retain a tight hold on practice finances. Typical descriptions of the role of the practice manager are as follows:

'Our needs for a practice manager are really in terms of managing the mass of paperwork that comes through the practice' (Female Partner 523).

'Working out what they should be doing, supervising what they should be doing, making sure it's all running smoothly, being the link between us, holidays and what not...So it's not one of the practice managers where, you know there's a new style coming up where it just does the entire administrative side of the practice and you're sort of advised what to do by the practice manager, she is intermediate between the two, she can keep us right but we actually have the actual management of what we're going to do and if we can do it. I think we want to be hands on, we don't want to leave it' (Female Partner 1528).

Description of the allocation of responsibilities within the partnership largely takes two formats: a) management led by the Senior Partner or b) decision making by consensus.

'Nobody makes a decision without consulting the other partner, so everything that is done has to have the agreement of both partners really' (Female Partner 523).

'Usually it is done mainly by talking to each other. If it's not a day to day matter then we will make a decision at a practice meeting' (Male Partner 1087).

'I think we do things as a team really rather than saying one person will do this that or the other. On the whole we take things into the practice meeting and we discuss it and feed it back through the practice manager' (Female Partner 1528).

The management time-frame tends to be short term, focusing on task orientated issues as opposed to the long term development of the practice:

'I think we tend to deal with problems as they arise. We don't have sort of any forward projections if you like' (Female Partner 523).

Practice size was clearly an important factor identified by GPs themselves when discussing the management and organisation of the practice. Whilst some respondents identified financial constraints as limiting the type of manager they could afford to employ within a small practice, it was also identified that practitioners in small partnerships chose such partnerships because they liked to maintain direct 'hands on' management of the practice.

'A lot of the small practices they have somebody who is practice manager in name only because of the financial constraints...if you are a small practice whoever you employ you get 70% reimbursement...if you are a six doctor practice that 30% is split between six of you, if you are single handed or a two doctor practice that 30% is hard to find.....I think single handed practice attracts a particular type of practitioner who likes to run his or her own management, and that is the attraction, that you are in charge of everything'

'So even if more funding was available you may not want to..'

'No I wouldn't' (Female Partner 523).

'You mentioned the new managers that are coming in, you wouldn't want to..'

'Heavens no. No I personally wouldn't want that. I'd have to trust them greatly, we've watched a bad experience in another practice quite recently where there was a great deal of power for this particular person and they totally abused it. I would be very wary of that. I am happy with the amount of management that we do. I think it works well' (Female Partner 1528).

The concept of being accountable for the management of finite resources to meet population, as opposed to individual patient needs was alien to these practitioners who viewed the 'rationing' of resources as a direct threat to their traditional role as individual practitioner responding to individual patient needs:

‘I have always been opposed to fund holding and we have not opted to be a fund holder at all and stood very firm on that.....I can look to retirement because I am still practising the sort of medicine that I wanted to practice when I qualified, I wouldn’t choose medicine as a career now, because medicine has changed and it is not what I want to do now. The way it is developing in this country is not what I would choose. I chose to do medicine for old fashioned general practice...the whole essence of British General Practice is that it gives scope for people’s individuality if you like, and that is basically what is being eroded, and it is a squeeze for the small practices’ (Female Partner 523).

In some cases GPs with a ‘traditional’ approach to management were in a partnership where a different approach had prevailed, causing tension and resentment:

‘Life has got very complicated these days. I must be perfectly honest with you I feel irritated. I feel it very much encroaches on the time I would like to spend on the patients and then like to spend on my private life...I am mainly an old fashioned clinical doctor, I think that is where my interests always were and it’s where they are now. I would very much like to go back to what I believe is our core function’ (Male Partner 487).

6.3.2 The Transitional Approach

The ‘transitional’ position lies between the two extremes of traditional and progressive. This approach finds partners handing over a greater amount of independence and authority to the practice manager, who they largely see as occupying a ‘middle management’ role as previously described. Such clinicians are unlikely to get involved in routine day to day decisions and look to the practice manager as a figure who can ‘take over’ the management side of the practice, implementing decisions made by the partnership.

‘We would be putting in more on the clinical side and Jenny would be doing the day-to-day management. I think you’ve got to communicate between the two to know what’s happening. At the end of the day I think the partners are the paymasters and need to make the final decisions’ (Male Partner 1352).

‘I try to delegate just about everything to the PM because he has done 20 to 30 years of managing and appropriate training where as I have been a GP and trained in medical things’.

‘So in terms of the future of the practice, decisions about direction and so on...’

‘He would supply information and facts and really it is a matter for all the partners to discuss...’ (Male Partner 1262).

GPs placed towards the middle of the model typically describe more developed management structures involving the development of departmental groupings headed and represented by supervisory staff. In some cases committee and quality circle structures had been created in order to develop greater employee involvement:

‘The Practice Manager is if you like the chair of all the committees he coordinates the working teams for all those areas. And then has overall responsibility for everything managerial in the practice. So he has overall responsibility above the administrator and the line heads’ (Male Partner 1254).

The allocation of management responsibilities across the partnership also appears to be more organized in respect of having designated functions, which in most cases, are rotated. Whilst this may suggest a more organised and formalised approach to management within the partnership there was significant cynicism expressed regarding the extent to which such responsibilities were actually played out in practice:

‘We don’t have anybody who is assigned as a staff manager, I bet DR Steel told you differently actually, because we will all say, it’s a sign of how things go on in practices, that sometimes these things are not quite, we have different perceptions of what goes on.’ (Male Partner 487).

‘Certain partners do have certain responsibilities within the partnership....one partner is supposed to be in charge of the buildings and he has failed miserably in that respect’ (Male Partner 1369).

‘There are roles in terms of the areas people are supposed to work but then the other side is actually who functions well at what, and who does what, those two may conflict. The structure of decision making is at best, led by one individual, and at times when we are under pressure we find that we will revert to erm, a less democratic way of making decisions’ (Male Partner 52).

GPs also begin to refer to the medium-term needs and development of ‘the practice’ as opposed to the efficient management of tasks. However there is little mention of the strategic development of resources to respond to identified practice population needs. In some cases there is an aspiration towards longer-term strategic management but a recognition that this was not yet being achieved within the practice:

‘I think at the moment that practice is not run certainly anywhere near as well as I would like...it is like a holding operation, you come in, see you list and see the emergencies and then that’s it. We don’t have any significant long term ideas other than moving into a new surgery at this point in time. We haven’t even had the time to sit down and formulate policies, business plans and that sort of thing as to where we want to go. We tend to, we are one of the practices who tends to say oh yes we’ll get a new surgery and then think what are we going to do with it, should we alter our services’ (Male Partner 1369).

In some cases the hand over of responsibility caused tensions and anxiety for those GPs who recognized the need to improve and devolve the management of the practice but feared ‘losing control’:

‘Certainly giving people authority is something we like to do, I like to do, but are the systems then in place to make sure that that has the authority of the partners. I am worried sometimes that a decision made may not yet have the approval of the partners. So there is something about the sharing of, it is either something about the rules of the delegation or it is something about the communication between the practice manager and the partners for example. This difficult thing of sharing a vision with a manager, and a manager taking it forward and doing something with it and then does it still fit with the partners perception of what might be happening’ (Male Partner 52).

6.3.3 The ‘Progressive’ Approach

Both existing practice management literature and primary fieldwork has seen reference to the ‘new breed’ of practice managers and GPs working together to deliver ‘strategic primary health care’, aimed at addressing the long term health needs of the practice population (Macmillan et al 1993). The ‘progressive’ practices are those who embrace the principles of strategic management and encourage the active participation and involvement of management personnel in determining the future shape of the organisation and the services it delivers (Huntington 1992). Whilst ‘transitional’ approaches may be prepared to hand over the reins of day to day management in order to focus on improving the overall efficiency of the practice, the truly ‘progressive’ practices are those in which managers, staff and partners work jointly to develop and deliver a longer term vision.

From interviews conducted with nineteen clinicians across the country and inclusive of fundholding, non fundholding, small, medium and large practices, one clinician described such an approach to management.

Emerging from a practice structure based on traditional management by a senior partner without a supporting practice management function, this GP charted a process of change which had resulted in a sophisticated organisational structure that promoted and facilitated the involvement of the entire primary health care team.

Commencing from the recognition that the Senior Partner was carrying too heavy a burden in the management of the practice, a Practice Manager was appointed in 1985 to work closely with the Senior Partner and reduce some of the administrative burden, in keeping with the approach taken by many practices at this time.

The introduction of fund holding within the practice was viewed as the turning point by the GP interviewed:

‘I think that’s really when things started changing because we realized that we needed strong management within the practice and, you know just the senior partner doing the books and writing the cheques at the end of the month wasn’t really good enough because you really needed stronger management within the practice’ (Male Partner 1361).

Following the introduction of fund holding a fund manager was also appointed, still at this time reporting alongside the Practice Manager to the Senior Partner. Recognising the continued management burden on the Senior Partner, a further decision was taken to elect an Executive Partner, a position occupied by the respondent over the last three years.

This period had witnessed a significant amount of change described by the partner as follows:

‘Then we came up with an Executive Management group structure and we felt really that first of all there was not a lot of grass root representation on decision-making in the practice. Certain sections of the practice were feeling alienated, some of the district nurses, the reception staff, they felt that really they didn’t have a say in how things were done. So we formed an Executive Management Group. The Executive Partner chairs that group and we have four team leaders sitting on the group....so each one of them has an elected representative sitting on that group where all policy decisions are made for running the practice’ (Male Partner 1361).

Various means of staff representation in decision making were in evidence in transitional approaches to management however what distinguished this particular approach was the level of decision making undertaken by the Executive Management Group:

‘So in terms of strategic decisions affecting the future of the practice, for example patient list size, fund holding...’.

‘Fund holding is a very good strategic example really because if you want to say, for instance, coronary bypass heart surgery, and there is a problem here because there isn’t enough funding for it and they’re going through these operations like nobody’s business, so we’re running out of money for it, so that’s a possible policy decision which we would take, a strategic decision as to how to manage that’ (Male Partner 1361).

As found in many practices, the introduction of new ideas had been met with resistance:

‘There have been people who are against it as well, like any idea and I think every now and again you find somebody throws a spanner in the works’ (Male Partner 1361).

With a particular interest in management and experience of commercial organisations via the delivery of occupational medical services, this GP had brought about significant change within the practice.

‘I’ve always been interested in management – generally speaking- and I’ve done a lot of occupational medicine, dealing with companies....., I’m also an aviation medical examiner and really that’s where I’ve studied these models. Not studied but I’ve come across how these things work, and I felt that really we could get something into the practice’ (Male Partner 1361).

The main principle at work in this approach was giving individuals the freedom to manage:

‘Well you see I think practice managers have been a very much undervalued commodity in general practice and it varies from practice to practice obviously, but I’ve seen practice managers being used as tea ladies and I’ve seen practice managers being used as top managers, and really if they are to be used to manage the practice they should be given that freedom to do it. As general practice becomes more complex...you really need strong management and the

only way you can have strong management is by giving people the freedom to manage...we wanted somebody who had vision for the future because we wanted to get ahead and do things and improve the practice' (Male Partner 1361).

Other GPs interviewed were seeking to develop this approach and encountering barriers both in the form of partnership opposition and in some cases the development needs of their Practice Manager:

'There is managing the structures right and making sure things happen in the practice ...which I think our structure is quite good at dealing with but there is another management function which I feel we are only just beginning to reach and that is setting the context, particularly in the clinical area and we are beginning to do that, to say this is what we want, this is what our needs are, this is where we need to shift or change and we are not so good at that, we are just beginning. You might have guessed I am quite interested in management and I feel we have a long way to go. I think all the partners understand and appreciate that there is a will and a way and it will happen I am the so called senior partner now, just a couple of years ago there were two people above me which made it very difficultShe (Practice Manager) is very useful at facilitating but as a strategic thinker, particularly in sitting down and saying what the needs of the practice are, you now we have X number of people smoking cigarettes we need to do something, she doesn't take that role. But we hope very much that that sort of thing will happen in future' (Male Partner 1377).

SUMMARY

Analysis of manager's perceptions of their role within the practice has indicated a wide range of approaches across the practices surveyed. From managing the paperwork associated with general practice to planning the future health needs of the practice population, Practice Managers are a diverse and varied occupational group.

Inequalities in practice manager rewards identified by macro-level data have been corroborated by qualitative work, with both senior and middle level female managers earning significantly less than their male counterparts.

Contrary to common perceptions in sector literature and assumptions expressed during the process of this research, managers operating at a strategic level were just as likely to be females promoted from within the ranks of general practice, as males with private sector management experience, pointing to a political process in which work

identities are socially constructed, negotiated and contested (McDowell 1997, Acker 1990).

Interviews with GPs identified three broad approaches to management presented as a continuum from traditional, through to transitional and progressive approaches. Traditional approaches to management in which GPs maintained hands on control of routine day-to-day management were largely found to be a feature of small non-fundholding partnerships.

Transitional approaches which delegated daily management tasks to the practice manager tended to retain significant financial and policy making decisions within the partnership, identifying an information provision and facilitation role for managers at this level. The latter approach is found in both medium and large fund holding practices and was the most prevalent approach amongst GPs interviewed.

The 'progressive' approach, described in practice management literature and espoused by policy reform was found in a single case only, whilst others claimed that they were working towards it. Engaging a participatory approach to management and encouraging the active contribution of managers to policy decisions, the 'progressive' view of management was rare in primary health care at the time this fieldwork was undertaken.

The next chapter explores the interaction between partners and managers in more detail, and evaluates the impact of recent policy changes on the management of clinical work at grass roots level.

CHAPTER SEVEN

MANAGING 'PROFESSIONAL' WORK

INTRODUCTION

Chapter three drew together a range of theories that point to a decline in the authority of professionals to exercise 'occupational control'. The professional freedoms viewed as being under threat are:

- Economic autonomy, the right of doctors to determine their remuneration
- Political autonomy, the right of doctors to make policy decisions as the legitimate experts on health matters and
- Clinical or technical autonomy, the right of the medical profession to set its own standards and control clinical performance (Elston 1991).

This chapter reviews existing statistics and findings from qualitative fieldwork in order to explore the extent to which professional power is in decline in each of the above areas.

7.1 Economic Autonomy

Ownership of the means of production is a central focus of the Marxist proletarianization thesis reviewed in chapter two. As detailed earlier, the thesis compares the transition of craft workers to the factory environment with the transition of professionals to employment in large scale organisations, in which the exchange of labour for wages leads to the surrender of ownership of the means of production and eventual loss of control over the process of production as work is progressively rationalised via an increasingly complex division of labour and increased mechanization of production.

‘The processes outlined by Marx and Weber with respect to a different group of workers, during a different historical era, is directly applicable to the changing situation of doctors today, now that the “industrial revolution has finally caught up with medicine (George Rosen)” (McKinlay & Stoeckle 1988: 197).

The most immediate point of distinction in the present context is the continued status of General Practitioners as independent contractors to the state, paid for the delivery

of services as negotiated by professional bodies and state representatives. Negotiation and retention of this status throughout all reforms to date has been a notable triumph for the profession in the face of significant pressures to adopt, what has been viewed by many policy makers, as a more efficient arrangement of direct employment. From 2004 contracts for General Medical Services are made between the Primary Care Trust¹ and the practice, rather than individual practitioners, however GPs still retain a self-employed status as partners in the practice (D.O.H 2004).

A small proportion of General Practitioners adopt alternative contractual arrangements including Assistants/Associates, who are employed to assist a GP Principal or to cover absence. The proportion of practitioners engaged in an employed capacity is extremely small at 2% of all General Practitioners, with employment being maintained within the context of a non-profit making partnership of other professional practitioners (The fund-holding scheme, whilst enabling savings in the fund to be re-invested in the practice, did not allow the generation of profit for private gain).

The structural circumstances of GPs in Great Britain are thus significantly different to those in the United States, where the proletarianization thesis was developed. Practitioners are commonly employed in Health Maintenance Organisations and free-standing primary care centres in the United States, variously operated on a profit and not for profit basis and being owned by large conglomerates and individual practitioners.

In contrast with the UK position, the USA has seen dramatic changes in the economic status of physicians. Between 1983 to 1997 the proportion of patient-care physicians working as employees (with no ownership in their practice) rose from 24% to 43%, with the figures for newly practising doctors rising from 37% to 66% in the same period (Kletke in McKinlay & Marceau 2002:388).

¹ There are 303 PCTs in England, each charged with planning, securing and improving primary and community health services in their local area. The PCT board is comprised of a majority of lay members, who work closely with the PCT executive representing general practitioners, nurses and other community staff (RCGP 2004).

It should be noted, however, that whilst a small minority of GPs are engaged in an employed capacity as compared with the USA, the economic autonomy of UK General practitioners is severely limited by the national negotiation of fees for items of service, with individual GPs having little control over the exchange of their goods in the market place.

Whilst individual freedom to control economic exchange is limited, ownership of the means of production does provide an important source of additional power in relationships at practice level. Thus in addition to working within the boundaries set by the clinical autonomy of partners, managers in general practice, as compared with the acute sector, also have the additional restraint of being employed by the 'shop floor workers', a factor noted by clinicians and managers alike.

Speaking of the role a manager should play regarding the use of prescribing and audit information within the practice, a partner states:

'We would want, all we want is information being pointed out to us and then we can make a decision so yes it is perfectly appropriate for a manager to come to us and tell us what the problems are and then for us to give him a brief as to the direction he is going to go in. The real peculiar thing in general practice is that you have what, anywhere else you have people working for a manager, but the peculiar thing in GP is that the doctors are the key front line worker ants as well as being the bosses which is a peculiar structure, it is upside down and back to front, most peculiar' (Male Partner 1262).

'I suppose it is in one sense in that I was my own boss in the branch previously and it is now a case of working with the partners, I am not a partner. I think that doctors, I think in many ways doctors should really try and be doctors and not try to involve themselves too much in the business commercial side of the practice particularly if you have someone who has the right experience. Not that I have much of a problem here just that from time to time the odd partner tends to involve him or herself in matters which, fair enough they have every right to have an interest in being a partner, but if they do employ a manager then they should do it through the right channels' (Manager Male 1455).

'I am here to manage the practice and to keep the doctors input on the management side as hands off as I possibly can but I am not a partner in the practice, I have got no say in the decisions in the practice. To a degree, I probably shouldn't normally take part in the partnership meetings because they are a board, if you look at a normal company they are a board of owners and I am working for them' (Male Manager 1254).

Many managers refer to GPs' ability to agree and avoid policies as being a result of their clinical autonomy. However the influence of positional power should not be underestimated, as one manager emphasized:

'Once a decision has been agreed, do the partners tend to stick to it? For the benefit of the tape you are shaking your head!!'

'Why ask me this question you know what the answer is going to be!! They will suddenly decide that they didn't agree to it after it is three quarters way through to achieving it or you might actually be doing it and they'll say I didn't agree to that, and I say, well you did. You have to go through the whole process of coaxing them round again. They are like any group of people together they get very childish, and it is not just true of doctors, although practice managers would have you believe it. But working in business, it's the same'.

'So you have found that in the private sector as well?'

'Yes I think it depends on who has got the power. People who have the power to control are the worst. People who are getting paid for their jobs, they have that limitation on them'.

'So it is more that they are the owners, the employers..'

'Yes, it is the same with a board of directors. In business I have found in advertising, the bosses disagreed, depending on their mood at the time.'

'So it is more to do with having the power as owners or employers to say "No I didn't agree to that" rather than their training and knowledge as clinicians?'

'Yes, I think they can act on a whim if they wish; they are free to do that. I once went on a course where they sketched a diagram of a solicitor's office. (Circle) That's a general practice, GPs are all little stars working within the practice, and the staff are all the little satellites outside. Stars, that really describes them, sometimes they will join together and they will work together, but more often than not you will get little rifts, one group working together (GPs), another group working together (GPs) if one of them gets fed up he will step outside and refuse to cooperate. These people (staff) have to work outside this all the time, it was a picture of a solicitor's office, but it seemed so appropriate to general practice. While they are in the practice they are individuals working together, if they get in a huff they will do everything they can to sabotage, to let people know that they have got the power and they very much resent managers getting a part of it' (Female Manager 1361).

This research has therefore noted some important structural distinctions between the position of GPs in the UK and United States, whilst also accepting that the constraints of national negotiations place significant limitations on the economic autonomy of individual partners.

The structural position of GPs as independent contractors working within sole-trader companies or partnerships is stressed as an important source of power with respect to

the relationship between practitioner and manager, with the former having the ultimate control over resources and the power of dismissal, turning the relationships found in archetypical bureaucratic organisations which dominate sociological study 'upside down'.

7.2 Political Autonomy

As Chapter One outlined, the national GP contract is negotiated by the GMSC and Department of Health. The introduction of the 1990 contract in the face of significant opposition from rank and file General Practitioners has been noted as a significant turning point in the bargaining position of the profession vis a vis the state and lends support to a thesis that professional powers are in decline.

The strength of GP opposition can be noted by a brief glimpse into the mass of coverage appearing in the professional journals of the period:

'Judicial Review on New Contract Opposed.' A proposal that the profession should apply for a judicial review against the decision to impose a new contract on general practitioners was defeated by a large majority by the General Medical Services Committee on 21 December 1989. Although defeated by 38 votes to 12, there were vehement pleas for a judicial review. Dr G H Shepherd said that ...he could not go back to his colleagues and say that the profession was not in dispute with the government' (Beecham 1990 1).

'A poll conducted on behalf of Doctor newspaper had shown that many general practitioners felt strongly about the contract. Of those polled, 89% opposed the new contract, 70% saw no advantage in it, and 78% believed that it would require them to work longer hours' (Beecham 1990 2).

A study of GPs' views on the contract commissioned by the Royal College of General Practitioners identified key concerns as follows:

- Changes in the relationships between the doctors and their patients
- Changes in the interaction between the general practitioners and their staff
- Problems in communicating with the Family Health Services Authority
- Partnership disagreements relating to the requirements of the new contract
- Increased paperwork and administration.

(Myerson 1992:19)

That such unpopular reform could be introduced against the will of the majority of rank and file practitioners was thus a significant blow to, in Elston's (1991) terms, both the 'political' and 'economic' autonomy of the profession.

To some extent the resistance of the profession to the 1990 contract was the result of increased intervention by the state in determining what tasks should be undertaken in the day to day delivery of general medical services.

The 1990 contract states that central to the Governments plans for improving general medical services was:

'...making the terms of service more specific to reflect clearly the requirements of good general practice that better practices already meet in serving their patients (e.g. Health promotion advice, full preventative cover, ready availability to patients and services geared to their needs) (DOH 1989 3:5)'.

With the content of medical services previously being viewed as the remit of the profession, Laughlin et al conclude in their review of practitioners' reception of the 1990 contract that:

'The requirements, particularly those related to screening healthy individuals, conflicts with the way many, if not most GPs think primary care should be going. Equally the new accountability requirements...are seen not only as a bureaucratic nuisance and irrelevancy but more importantly they are seen as a breakdown in trust which has dominated the partnership between Government and the GPs throughout its history' (Laughlin et al 1992: 145).

Further to target setting for itemised service elements, the Government also introduced priorities for improving health care at the strategic level with the introduction of the 'Health of the Nation'. Research by the author (Cheung et al 1997:314) investigated GPs' attitudes towards the Health of the Nation Targets and views on the extent to which they were achievable. Resistance to the targets was strong with practitioners contesting the feasibility of targets set and the implication that primary care could influence behavioural and socio-economic causes of ill-health:

‘Obstacles to pursuing the targets at practice level were: excessive workload in the primary health care team, targets too ambitious, time scales unrealistic, apathy among patients, and lack of funds. Comments also centred on the lack of influence of the primary care team over socio-economic factors linked to ill health..’(Cheung et al 1997:1251).

Resentment at what was viewed as ‘interference’ in the clinical sphere was voiced in interviews with partners, as expressed in the following comment from a partner explaining low morale in the profession:

‘It is because of the politics, the white paper came up two, three four years ago...people who are monitoring what we are prescribing, dictating what we can’t and what we can, and then they look at costs’

As chapter one indicated, this was not the first occasion that the collective profession was forced into the acceptance of terms against their will. However, it did represent a marked change in health care policy and supports the view that the professions are being ‘challenged’ by the state to change their approach to service delivery, in health care as in other public services.

7.3 Technical Autonomy

As chapter two indicated, in a ‘professionalized’ service the organisation's central task, around which all other supporting activities are organised, is performed and controlled by professionals.

‘When the central strategic task of an organization is formulated, controlled and evaluated primarily by the workers, as it is in the case of the established professions, management does perform logistic functions, but is essentially stripped of what Weber considered to be the prime characteristic of administrative authority – the legitimate right to exercise imperative coordination’ (Freidson 1973: 24).

Have the developments of the late 1980s and early 1990s strengthened the hand of the Manager in primary care? To what extent do Managers shape the organisation and delivery of services in primary care?

Whilst analysis of policy would suggest an increasing imposition of directives on the form and content of general medical services from the centre, interviews with

managers at the grass roots in general practice cast doubt on the theory that professionals authority to retain control over their work is diminishing.

7.3.1 The Management of Clinical Work

Managers were most likely to describe their connection with clinical work as providing the facilities and environment for professionals to conduct their work, the standard of work itself being perceived as clearly outside the remit of the manager. This equates to the role of the NHS Administrator prior to the introduction of 'General Management' into acute health care settings:

'Rather than being, as one might expect from the management textbooks, someone who shaped the NHS and controlled its direction, he or she helped to provide and organise the facilities and resources for professionals to get on with their work, and helped to mediate conflicts within the organisation' (Harrison et al 1994:36).

This was a common finding across all management roles, including supervisory, middle and senior level managers.

'Are you involved in managing or organising clinical work in any way?'

'Just as far as the rooms and availability of space and rooms, purchasing equipment and stuff like that, but really no everybody does their own' (Female Manager 1087)

'So if you were to advertise your own post and summarise what it is and what it entails could you do that? '

'It's the (long pause) management of the practice, all aspects of the administrative, non-medical areas. In summary everything that doesn't involve doctors talking to patients, maintaining that environment for these professional people to get on and do the job unhindered' (Male Manager 1077).

'What about your involvement in the clinical side of the practice?'

'Yes, from the operations point of view I am very involved, we would like to set this up and how can we do it. I mean the clinical side of things they decide amongst themselves, what they want to achieve, and then it is Janet, how do we get it, how do we organise it' (Female, Manager 1382).

'Are you involved in managing the partners' activity as well? '

'There are partners' meetings and things come up in there'

'So you always attend those?'

'Yes'

'What kind of input would you say you have there?'

‘On the clinical side, very little, but again it is on the systems side on the way we do things. We had an incident a couple of weeks ago where I got the fire officer in to check over the fire safety systems. One of the things they said we ought to have was stickers on the fire doors saying, you know, keep this door shut this is a fire door. I put this to the partners and they said “Oh no we don't want this it will spoil the look of the building” And I said well what happens if we have a fire, “Oh it doesn't matter”. And it's things like that where I really have to say well you have got to do that because its a legal requirement. At the end of the day managing them to see that can be quite tough’ (Male, Manager 487).

7.3.2 Clinical Guidelines and Procedures, Audit and the Management of Performance Information

Much analysis has focused on the introduction of clinical audit, evidence based medicine and clinical guidelines as measures that increase management surveillance and control of clinical work. In the context of general practice, interviews with both clinicians and managers would suggest that the introduction of such initiatives have had little impact on the distribution of authority between managers and clinicians at practice level.

‘We have also looked at audit, this glorified idea that audit feeds the management cycle and supports it, but that I am afraid is more rhetoric than reality. We did identify someone (partner) who does that’ (Male Partner 52).

When asked about the introduction of guidelines, most managers and clinicians identified measures that had been introduced in respect of the practice nurse role rather than partners’ clinical activity:

‘What do you think about the idea of guidelines?’

‘I think obviously with practice nurses we are developing quite a lot of guidelines and we have got guidelines for most things now within the reception area from dealing with a complaint to what do you do if you have a repeat prescription. I mean we are getting there but it is a long job as you can imagine. We have got Protocols for the likes of vaccination, immunisation, maternity and all of that, which are clinical guidelines really. I don't think the partners and I don't really feel the practice would want to have hard and fast guidelines for referral and this sort of thing because it's a partnership of four and in theory there is no senior partner and they like to have a bit of freedom, and nobody is going to turn around and say to the other one "why did you refer him to him", because it's clinical decision and I don't think that would ever happen’ (Female Manager 1521).

‘We have protocols, clinical protocols will be done between the nurses and the doctors e.g. for how to deal with asthmatics. They will have guidelines for running the asthma clinic, certain pointers where they will say the nursing responsibility ends and it should be referred to a DR’ (Female Manager 1361).

‘Yes, we have protocols for taking appointments for coil insertions and coil removals, that the girls must go by when they’re discussing these things over the counter with patients. If I’m not here or the nurse isn’t here...normally they would come to me or doctor or nurse if they want a coil removed, but we do have a protocol for that. A protocol for smears, taking appointments for smears’ (Female Manager 1522).

Expansion of the nursing role and the roles of professions allied to medicine have also been identified as a threat to medical dominance, associated with clinicians becoming more specialized within certain areas of medicine and opening up new divisions of labour over which medics may have limited control (McKinlay et al 1988).

Frequently evidenced with reference to the acute health care sector, analysis of data from interviews conducted in primary care suggested that the introduction of clinical guidelines, focused chiefly on the activities of nursing staff, enabled clinicians to hand over routine elements of treatment whilst maintaining clear demarcation of roles and limits to independent authority. Contrary to undermining doctors’ clinical autonomy, therefore, this could be interpreted as extending their means of surveillance over other workers in the primary health care team:

‘Are there areas where management and clinical issues overlap?’

‘Well yes, for example embarking on the concept of the nurse practitioner, whereby the nurses in the practice do a little bit more than just nursing. They start to see people with say, earache, sore throats, traditionally things seen by the doctor. Now there are a lot of issues involving management in that, arranging suitable training for the nurses, the receptionists need to know how to divert patients, the whole paper side has to be co-ordinated, rooms equipment. That has been taken on by the line head of the practice nurses who will co-ordinate it. I am not bothered how the rooms get organised etc. but I know I need to set protocols for the nurses, and over- look the training, give tutorials, the rest just runs’ (Male Partner 1254).

The role of the manager in setting or monitoring the extent to which procedures were followed was minimal, with most managers viewing this as the role of clinicians and nurses with appropriate administrative support:

‘We are now developing protocols in various areas. We have for the most part allocated that to individual doctors because they are the only people who are in a position to determine what is required, when it’s required and so they are the ones who are actually developing those guidelines. My involvement as far as the practice protocols are concerned, stops outside the door that’s the various protocols that are governing the way receptionists will deal with particular situations, how they deal with antenatal clinics, from when the patient first comes in and says I’m pregnant till the end of the story. But that’s not clinical; it’s an administrative support process’ (Female Manager 1077).

‘How about audit, are the partners involved in any, do you get involved?’

‘It would be true to say that in terms of audit that could be presented to the MAAG, they are a little bit involved at the moment but it is proving very slow. There is a little bit at a much lower level. Internal audit. I would argue of not the most accurate and professional style.’

‘Are you involved in that at all?’

‘Well most of it is clinical. I doubt sometimes that we are getting a genuine answer. One doctor seems to be more interested in getting an answer, which suits him.’

‘So would you feel it was your place to maybe intervene and suggest other methods, other ways of organising the audits?’

‘If asked I probably would, if I felt strongly enough about it I probably would. But as it would only increase the amount of work that I would have to do, I’m busy enough’ (Male Manager 364).

‘So for example, have clinical guidelines been developed in the practice?’

‘Protocols? Yes for diabetes, asthma’.

‘Do you have any part in that?’

‘Oh Yes - in some parts we tend to put protocols together but nurses and GPs would do it and come and I would just lay it out more or less. But in that side I am not trained in that side of clinical procedures.’

‘So you see that as a fairly clear dividing line?’

‘Yes - I would never presume to know about the clinical side or anything like that. I mean, I order the vaccines, I know the prices of them, I book them in, I know what they are, but I wouldn’t presume to even attempt to lay a protocol down for a nurse and there are clear lines. I will type it out and lay it out and word it, they tell me what they want and I will word it, and submit it to where it has to be submitted, but it’s the GPs and the practice nurse’ (Female Manager 1087).

‘Is it mainly the doctor’s responsibility to make sure the clinical guidelines are followed or do you have a role in monitoring that?’

‘I think the doctors normally do that. We do have a clinical meeting every two weeks on a Wednesday and things are discussed then but mainly it is between the doctors’ (Female Manager 1461).

Managers classified as undertaking a ‘senior’ management role described a more direct involvement in the development and interpretation of performance data however. This role tended to be described as a ‘facilitative’, assisting clinicians to see the ‘wider picture’ outside the individual consultation and flagging up where problems may be arising:

‘Do you think there is a role for practice managers in that, looking at guidelines and relating them to their own GPs?’

‘I do, Yes I do because I don’t think it’s just down to finance. I think it is down to organisational skills, looking at things more logically rather than, I think the clinicians obviously have to be involved, they have to be because we wouldn’t know enough clinical, well we wouldn’t know the medicine to make those sort of decisions. But I do think a lot of it is about organisational attitudes rather than clinical, that sounds as if I am dismissing the clinical, I am not I just think that they compliment each other. I don’t think GPs or clinicians are necessarily trained, they are trained to look at a patient as an individual and they don’t see it within the whole context, and it is sometimes the clinicians at this end of secondary care understood the chaos that is caused in primary care through inadequate discharges, etc. But also at their end, the administrator would probably say if the GPs out there understood the chaos that are caused within the secondary care sector of inadequate referrals from primary care, then we could actually get somewhere. You then get into rounds of what is necessary, what is urgent, what could be dealt with in primary care, then the money could be all targeted to the more appropriate places and things like that. So I think there is definitely a role for management within the organisational bit’ (Female Manager 1530).

Clinicians identified a minor role for management staff which mainly involved the collation and provision of information for interpretation by the partners, as opposed to an inspection or surveillance role vis a vis the quality of partners’ work. The principle of ‘clinical autonomy’ was evidently still very strong:

‘Would you say the partners work as a team, or do you tend to work more as individuals?’

‘Probably more the latter, we work in a team in the sense that everyone has got clear cut duties which you understand that is what has to be done, no-one, we don’t have practice protocols that are strictly adhered to. We do use guidelines

for certain things, we don't have practice formularies, we do like to retain our independence in the way that we deal with a particular problem, we liase with each other over particular problems, so it is more a kind of coming together' (Male Partner 1369).

'Once guidelines are in place would you say they are generally followed....'

'They are reviewed every now and again; as to followed strictly I think it depends on who does it'.

'Right'

'If you are talking about the nurses I think they follow it very strictly, if you are talking about the doctors they don't.....they can produce as many guidelines as they want, I think people still do what they want to at the end of the day. At least we do. But the nurses are much better at doing that. That is the way they are trained'.

'So the nurses are possibly trained to adhere to things in the way of guidelines, you would say that isn't particularly the way GPs are trained?'

'Oooh, I don't think so no. Most people are independent you know, and they quite like being advised, they will follow the advice that seems reasonable but you can't have guidelines to cope with every situation. We have the problems to deal with usually; if the nurses or somebody else has a problem then they usually refer it to us. And that is where guidelines are not helpful, they are periphery, that is the problem'.

'And would that mainly depend on whether it was a straightforward clinical decision or something that would affect more the running of the practice?'

'It is often more the running of the practice. Clinical things people will, you can agree about them and then do what you want. You know. Things like, how much are you going to pay the staff, everybody has got to agree that' (Male Partner 1376).

7.3.3 Prescribing Data

Curbing prescribing costs, which are a significant proportion of spend in general practice, has been an issue which various administrations have tried to tackle. The 1990 contract also targeted this area of health spend as an issue in which FHSA's were to have greater involvement:

'Family Practitioner Committees (replaced by FHSA) are to become involved in prescribing. For example they will be expected to encourage the development of repeat prescribing control systems and local formularies. In England and Wales they will cooperate with the DHA to establish rational prescribing policies covering both the FPS (Family Practitioners Services) and hospital and community health services in their areas, and they will in future monitor individual practices' and doctors' prescribing, making use of the PACT data' (DOH 1989:15)

Prescribing is identified as a major component of clinical autonomy (Davis 1997), it being an area where the medical profession have long fought to retain control from the incursions of nursing, professions allied to medicine and the pharmaceutical sector. Britten notes that:

‘Prescribing is one of the core activities that demarcate the medical profession from other groups (the advent of limited prescribing by nurses notwithstanding). The fact that the same word (medicine) is used to signify both the profession and the substance prescribed underscores the closeness of this association ...Prescribing is one of the few activities that is within doctors’ almost exclusive control’ (Britten 2001: 479).

Britten identifies prescribing in UK general practice as :

‘....a battleground on which the cause of clinical autonomy is defended. The act of prescribing can bring general practitioners into conflict with other parties who threaten their autonomy, notably the state, patients, other doctors and, to a lesser extent, pharmacists’ (Britten 2001: 480).

During the period under study, fund-holding practices managed the prescribing budget directly, whilst non-fund holding practices were allocated an ‘indicative budget’ managed by the Health Authority. Incentives within this system enabled cost savings made on prescribing budgets to be vired for other purposes within the practice.

‘PACT’ (Prescribing Analysis and Cost) data comprises GPs personal prescribing data compared with those within the same practice, the local area and the country as a whole, collated and distributed to practices on a quarterly basis. FHSAs/Health Authorities employ medically trained advisers to assist in the management of prescribing costs, by advising and influencing individual GPs whose drug costs are viewed as inappropriate.

Weiss and Fitzpatrick (1997) whose study focused more on the relationship between practices and the FHSA, as opposed to internal management personnel, draw parallels with the employment of such ‘medical advisers’ to the appointment of ‘physician managers’ in US hospitals, engaged to pursue management objectives and introducing ‘vertical stratification’ within the profession. This term is used by Freidson (1994) to

describe the adoption of management responsibility by clinicians over other clinicians as a defensive tactic to manage external incursion into clinical freedoms.

The emphasis in the current work however was on exploring the use of PACT data within the practice itself, identifying who dealt with the data and the uses to which it was put.

Most managers described an administrative or 'information providing' role with respect to the data, including both 'supervisory' and 'middle' managers:

'Just touching on that, with the issue of targets and PACT data, would you say that gives you any kind of influence over the clinical side of things, how is that data dealt with in the practice?'

'The method of collecting the data and preparing it for distribution in the practice, that's as far as my responsibility goes'

'So it is basically an information providing role?'

'Yes' (Male Manager 384).

'Things such as prescribing data, are you involved with that at all?'

'It goes in the annual report, we do, well I compile the annual report and I compile the health promotion banding. It is figures, statistics, erm, it is like small searchers really, small audit if you like and then just give them the figures at the end and say there file that, and that goes away' (Female Manager 58).

The latter description of the use of the data would indicate that it was neither reviewed by the Manager herself in terms of assessing individual practitioner activity and resource spend, nor by the partners as a means to peer review.

In other cases, the practice manager had no role whatsoever in the receipt or interpretation of the data:

'Are you involved with any data that comes in on clinical practice, such as the PACT data?'

'No that goes straight to the doctors, Dr Samuel is the one who sort of looks at it in depth but no, I don't have anything to do with that.'

'Would you like to?'

'In some ways yes but then I don't know enough about the drugs it relates to anyway, and a lot of it doesn't mean a great deal to me, I think you have to be medically trained' (Female Manager 523).

The majority of managers saw performance information such as the PACT data as a 'clinical' issue which required specialist training to interpret and act upon, therefore being the exclusive province of doctors. This was very common in supervisory level managers who had worked in primary care settings for many years.

In some cases, however, managers felt they had more to contribute, identifying the organisational problems caused by clinicians adopting differing prescribing practices and the negative impact on patient management:

'I think prescribing is another one, I know, then there is oh we have our own formulary, but you have the hospitals discharging people on drugs that practices doesn't use, or that the GPs think are terrible, or are too expensive, you have the GPs prescribing things that they go into the hospital and they say oh we never prescribe that. The patient is the one in the middle who is left all confused, so I mean, the medical adviser should get off their backsides and do more work on this' (Female Manager 1530).

In some instances managers would welcome a more direct role in decision-making and policy formulation but were prevented from taking a more active role by the partners:

'How about prescribing data, how is that handled?'

'In theory we have one doctor who is in charge of it, and he doesn't do much on it to be honest. The girl who helps me on fund holding is actually one of the assistants. She does a lot of work on that, shows them graphs, comparisons and what they are spending it on, it's all pinned on the common room wall. So they tend to go 'oh'. They have not done an awful lot on managing it, they have promised to look at it, but again generic prescribing is reasonably high, erm, and it would take a big decision for them to do something different.'

'So do you think it is a Doctor's place to decide what to do?'

'Yes I do. I think it is my business to point out to them what is happening, because last year we made savings on prescribing, and this year we are well over spent, so I think it is my job to point it out to them to show where we are over spending, but I believe it is their decision as to whether they do anything about it.'

'And that is based on the fact that they are clinically trained?'

'Yes, yes.'

'So you don't think these decisions are really management decisions?'

'Well they could be and in some practices perhaps they are, but that wouldn't be acceptable here, the doctors wouldn't like me telling them what they could and couldn't spend their money on.'

'Say you were in a different practice with different partners, would you be more prepared to do it there?'

‘Oh yes, I think the more managing a manager does the better quite frankly’
(Male Manager 52).

In other cases managers were prepared to raise the issue with clinicians, always on the grounds of financial cost and not with respect to clinical need or appropriateness:

‘Do you find that things ever cause conflict between the partner and yourself?’

‘I think there are more increasingly now - because of indicative prescribing and I have to keep an eye on how much we’re spending each year - I mean in terms of what the FHSA have set our budget on and that often he feels “I prefer to be left to prescribe the way I want to prescribe” and perhaps that’s one area.’

Challenging partners in an area which involved ‘clinical’ activity was viewed as very difficult by those managers who felt they did have a valid contribution to make:

‘Clinicians have a higher authority and it is very hard to break that down. Some of the difficult things, for instance I have had to say our, erm, there was a comment, that our prescribing budget was going over and it would be difficult to control and what could we do. And when that conversation had finished I had to say that isn’t good enough. If we over spend we have to pay for the over spend, and we cannot, so we have to do something. And that was difficult, because it is that relationship between, I sometimes think that medicine is a myth and one day someone will blow a little puff of air and blow the myth away from medicine, but at the moment it still has that aura to it, and it is very difficult to order, argue the clinical issue with a doctor. Erm, so sometimes that is very hard indeed, and one must never sound like a proxy doctor, or as if you are trying to take on their role. So I find that very hard’ (Female Manager 1398).

In describing where a manager may have an input in clinical work within the practice the following partner noted:

‘and then costs as well, drug budgets, you know a manager saying you are prescribing this very expensive drug why don’t you prescribe. We may well say well there are jolly good reasons to prescribe something else so you know’
(Male Partner FH Medium 1262).

Those managers raising the issue of prescribing costs may therefore have the authority to challenge on the basis of cost, but the ultimate authority rested with the clinician to prescribe as he/she saw fit.

Other clinicians would not expect the practice manager to have any role whatsoever:

‘In terms of say prescribing data, does she have an involvement in that?’

‘No, not a thing, that is purely the partners who look after that. I don’t think it would be appropriate because she doesn’t have the necessary time, and also I don’t think has the necessary skills’ (Female Partner 523).

It was suggested by some GPs that the prescribing budget wasn’t a ‘real cost’ so the partners would be unlikely to view it as something they would have to address:

‘Issues such as prescribing data, would you see the management side of the practice having any role in looking at that?’

‘Right. They don’t, they could do, erm, the problem at the moment with that is, is actually, and realistically does it matter? Erm, because from the budget point of view, it is not a real budget in terms of it makes, I mean the partners will focus, if I point out that financially we are going over drawn this quarter, then that tends to focus the partners’ minds because that is real money, and they will say well what can we do about this. Erm, but if we say to them well we are going £60,000 over drawn on our PACT data this year, it is not real. So they don’t engage with it as a real problem, whereas actually in managing the fund it is a real, it is a real problem in the sense that it would be good to manage it, erm, so I suppose to answer your question, it has got to be, it has got to be a reality thing. What is being suggested or put forward as an issue has got to mean something to the partners, so yes the manager should respond, but it is what is she actually managing? Is it something which is important to the partners? Or not?’ (Male Partner 52).

This was also raised in a study including interviews with FHSA Medical Advisers undertaken by Weiss and Fitzpatrick:

‘One of our biggest problems is that we still get the ‘so what’ response. So you’re going to be on a massive overspend, so what? Our answer is well, people may not get operations done next year but that doesn’t come home on a personal basis. They can’t relate it to their own individual patients’ (research respondent quoted in Weiss and Fitzpatrick 1997:307).

There was evident resentment on the part of some clinicians of the perceived ‘intrusion’ of the government in this area of their practice. Describing the reasons why he felt morale was low in general practice, the following clinician identified state involvement in the detail of health care as a key factor:

‘So people are being put off by the amount of paperwork?’

‘Of course, and also the people who are monitoring what we prescribe, dictating what we can’t and what we can, and then they look at costs and they are prepared to give financial incentives if we prescribe generic drugs and the cheapest form of drug which may not work.’

This again is confirmed in the study by Weiss et al, as in many others:

‘They just don’t like the thought of outsiders going in and telling them what to do. Many are in general practice rather than anything else because they like the independence of it. They like to be able to make their own decisions’ (research respondent quoted in Weiss et al 1997:309).

The above feedback would suggest therefore that the imposition of new data collection arrangements and surveillance on the part of the FHSA had not had a significant impact on the clinical freedom of clinicians. Whilst some practice managers felt they had a role in raising over-spend as an issue, their authority extended to the ability to put the discussion on the agenda, where partners could then do as they saw fit, including maintaining a position of status quo.

Weiss et al found that in respect of external medical advisers employed by the FHSA/Health Authority, a range of non-confrontational tactics were used to change GP behaviour:

‘The medical advisers interviewed had carefully considered a range of methods by which to influence general practitioners’ prescribing and to communicate the principles of rational prescribing. They were aware of the limitations to different methods and had developed an eclectic approach by adapting the method to suit an individual GP.....by the micro-management of attitudes rather than more confrontational methods’ (Weiss et al 1997:309).

It would appear therefore that the relationships between both practice managers and GPs and FHSA/Health Authority personnel are more facilitative than coercive, an approach which is:

‘...in stark contrast to the direct imposition of rules, where adherence is routinely monitored, that is described by MckInlay and Arches (1985) in relation to doctors in American hospitals’ (Weiss and Fitzpatrick 1997:309).

7.3.4 Defining the Purpose of the GP Role: Clinicians as Strategic Purchasers of Health Care

One of the overt aims of health policy change has been to introduce greater awareness and accountability of professionals for the public monies they commit by everyday decisions. Thus the fund-holding initiative gave clinicians a fixed budget within which they must purchase a defined range of procedures for the patient population. With finite budgets for a range of treatments, GPs were for the first time, given financial limits on the referrals they could make to secondary and community care services.

The fund-holding scheme has undoubtedly been the centre of much contentious debate within and outside the health care sector. The General Medical Services Council adopted a negative position towards the scheme from its inception, identifying the key reasons for its opposition as follows:

- A patient's confidence in the doctor would be affected by the knowledge that the doctor is a budget holder
- A patient's trust in the doctor could be undermined when he or she is advised that medication or investigation is not necessary
- Illness cannot be slotted easily into predetermined groups or packages of care
- Disputes over the costs of clinical treatment will damage relationships between general practitioners and hospitals
- NHS administrative costs will be increased at all levels
- Doctors will have to spend more time on administration instead of on patients
- Budgets impose cash limits on the clinical care provided by general practitioners, who will be responsible for keeping to them
- No pilot studies have been carried out or evaluated.

(Beecham 1990 3)

Without exception GPs identified an increase in the demand for effective management due, not only to an increase in practice size, itself associated with changing policy

demands, but more directly as a result of policy agendas to increase the efficiency and effectiveness of health care services:

‘Once we went fund holding, I think that’s really when things started changing because we realised that we needed strong management within the practice and, you know just the senior partner doing the - writing the books and writing the cheques at the end of the month wasn’t really good enough because you really needed stronger management within the practice’ (Partner Male 1361).

‘FH certainly kicked us into action, we realised we couldn’t get away with it, because that in itself created a necessary area of expertise, meetings, back up staff, so that certainly made us think more managerially’ (Partner Male 1254).

Some managers identified with the cultural changes sought by government:

‘Prior to 1990, general practice did not see itself as a business, and it has sort of been kicked and pushed, screaming, and fighting all the way to have to accept that we are a business and we are running as a business, and as such we have to satisfy the needs of the customers. Therefore, you know, it is not acceptable any more for practice staff to just sort of answer the telephone and say 'Yeah'. We have got to be professional, the staff have got to be more trained, we have got to respond to the needs of the customer. The way we run the practice is customer led, or it should be. I think these are the reasons why. Now, you have got staff in general practice who have got something between their ears, and it is probably quite useful to have people who have worked in the private sector, because we are just coming into the way of working that the private sector worked in for years and years. As always, NHS organisations are the last to jump on the band-wagon aren't they?’ (Female Manager 394)

Whilst fund-holding clearly had an impact on perceptions of the need for management in the practice, the extent to which GPs have been ‘incorporated’ (Salmon 1995) or in Derber’s (1983) terms become ‘ideologically proletarianized’ into a health care management, as opposed to practitioner role is less clear.

‘In practice the fund holding is virtually invisible to the partners on a day to day clinical basis and that was a decision that was made right at the beginning. There was a little bit of resistance to fund holding, the vocational thing around I am not going to base my clinical decisions on pounds shillings and pence, so really I was beholden to keep it out of the way so to speak. But having said that if they are more financially aware it’s because they have wanted to be, but I know one of the partners said not so long ago that fund holding was, there was an article about patients don’t like fundholding practices because they feel it’s all down to cash, and the partners here were in an uproar and said they had never ever considered cash and one of the partners who was most against it said “it’s worked wonderfully here it’s kept completely out of the way we get on with

being practitioners". But I watch what they are doing. I just manage the budgets quietly behind them, if I perceive a shift in the contract then the next year I will say do you want to change the contract and send 5% of radiology to X because that's what is happening' (Female Manager 1295).

In some practices however, fund-holding had opened up debate about the allocation of resources with respect to meting population as opposed to individual needs:

'With us being fund holding, erm, I don't know how much you know about fund holding but, certainly we do need to be accountable for the sums of money we are spending, you know the government has given us huge sums of money and we have to show that we are using it properly. So we do meet on a regular basis, the fund manager and myself and the partners, on a four weekly basis. And erm, yes, we are very open about it, this isn't being managed right, and this, I am referring to the fund alone, and how can we use this money better, erm, for the good of the patient really, let's not waste the resources we have been given. So yes, so this partnership meeting we have takes two parts, one is the fund holding element, and then the next is the more general business side of things, so yes we will very openly discuss those sorts of issues' (Male Manager 1382).

All practices are required to designate a lead partner on fund holding, and in some cases the allocated GP appeared to 'manage the fund holding side of things' as a separate and discreet task within the practice.

'One of the full time partners takes most of the managerial interest, the managerial input, he has done a part time MBA at Durham and, that has been really really useful plus he seems to be naturally gifted, it has to be said, even before he did the MBA he really seemed to have a firm hold on a lot of things. He does most of the management; he over sees the finances, over sees the office running, the fund holding side of things. We are trying to learn a bit about fund holding, but we really have got nothing to do with fund holding, so it was his main decision. I think he was looking for somebody with a good firm grasp, not just with the day-to-day running but also of needs for the future. You know, strategic sort of ideas' (Male Partner 1382).

'Dr Smith is the fund GP, the other partners haven't taken much of an interest in it until say the last six months when they have tried to get interested in it. They don't understand a lot, you know, the background of it' (Female Manager 52).

There was little evidence to suggest however, that the 'lead GP' was adopting a position of 'authority on the basis of office' (Freidson 1970) with a management role in respect of partner's clinical practice.

Opposition to fund-holding remained strong in some practices:

‘I have always been opposed to fund holding and we have not opted to be a fund holder at all and stood very firm on that. I feel that it has undoubtedly created a two-tier system. There is a very very definite documented evidence of things that are going on, and things that are going on within this city where fund holders can get a certain service and non-fund holders can’t. And it is documented and the consultants will tell you, that they do provide different services because they are forced by management. I just feel we are all chasing the same amount of money. I think that fund holding has caused big problems in that a disproportionate amount has been thrown at practices for the management. A lot of practices, and GPs have said “oh well I am only in it for new computers”, and they have seen it as a way, because funding is tight, if we were all fund holding then we would see real problems because then there would be no advantage to anybody and the amounts of money that fund holders got originally would dry up. And we are already seeing just the beginning of problems where practices are running out of money, where hospitals haven’t costed things, and they have not been able to cope with inflation’ (Male Partner 523).

In terms of the management of clinical work, therefore, there is little evidence to suggest that fund holding has significantly changed the authority of the manager in general practice. The initiative has, however, made a significant impact on the general status and rewards of management and the profile of managers in the sector as explored in chapters six and eight.

7.3.5 Practitioner or Practice Led?

Earlier chapters provided the context to the development of the medical profession and its position within the UK National Health Service. Central to that development has been the model of a professional service organisation based on self-regulation and collegiate control.

Collegiate control, based on the model of a ‘company of equals’ has been the accepted mode of operation for general practice described by Barber as:

‘A social group in which each permanent member...is roughly equal in authority, self-directing, pursuing the goal [of his work] under the guidance of the ...morality he has learned from his colleagues and which he shares with them. The sources of purpose and authority are in his own conscience and in his respect for the moral judgement of his peers. If his own conscience is not strong enough, the disapproval of others will control him or will lead to his exclusion from the brotherhood’ (in Freidson 1972:185).

The concept of the 'company of equals' in which each practitioner is free to practice as he/she sees fit on the basis of a commitment to professional ethics and appropriate level of technical training has been the dominant 'ideology' in the delivery of medical services.

What role does the practice manager hold in such a 'company of equals'? Has 'managerialism' replaced 'individual conscience' with common organisational objectives, practice and procedures?

Feedback from interviews with practice managers and clinicians would suggest that there is still considerable autonomy in primary care organisations of the 1990s.

It was clear in some practices that even the most basic of functions such as setting up and operating an effective appointment system, was beyond the control of the Practice Manager and developed on the basis of the individual preferences of practitioners:

'The thing is we have an open surgery in the morning, 8.30 to 10.30 so we always run over. It's part, we are one of the few practices that have open surgeries. When Dr Pinkney came 15 years ago the previous GP preferred open surgeries he thought it gave the patients more freedom. So we have always carried on but it does cause problems. The other partner has appointments so she has people coming in at specified times'.

'So you run two systems'

'Yes two systems really. So really the patients have the best of both worlds'.

'Does that cause problems for the reception staff at all?'

'OH it can do yes.....the receptionists are quite au fait with it. As they say they have their good days and there bad days so it's not bad every day' (Female Manager 1244).

'Do they have their own individual work patterns or do they follow a common system....'

'No, they are very individual. We are constantly tinkering with our appointment system one of the things we haven't cracked yet is how to cope with the differences in time, which they take. We have a couple who keep very well to time and one in particular who always falls behind. I suppose it suits the patients because they don't go anywhere else but yes there is difference.'

'Is that something you would like to change?'

'Oh yes, we have actually done a patient survey, I suppose deliberately so I could tell them this came out as a complaint. So it made them address it and we did an audit, it was only partially successful, to be honest, and is simply because

they are individuals and they are very difficult to actually change.’ (Male Manager 1262).

Many managers reported difficulty in getting partners to agree a course of action or common policy to address issues facing the practice. Lack of a hierarchy across partners meant that at any time any partner could veto a decision:

‘The main problem is getting them to agree between themselves, because there are five partners here with very different personalities. And it is quite difficult sometimes to get them all to agree themselves. And that can be quite frustrating when you set timetables to implement things’ (Male Manager 487).

‘There is a plan that we are half way through, we had an away day in January and at least we got down to putting down objectives of what they wanted, what they wanted out of life and what they wanted out of the practice, and how we were going to achieve that. Keeping them on that course is difficult but at least we have a course and what that day taught me was there was there are 6 different people all with 6 different agendas, but at least they had written down their aims and I spent the whole weekend afterwards typing it all up in booklet form, so that I can actually go back to them and say “this is what you said, this is what you wanted. Has it changed? And if it’s changed it has got to be a full partnership agreement that has changed. You can’t just go off on your own and change it”’ (Female Manager 1295).

‘We have got four partners, and every one of them is totally and utterly completely different. So that again, that, it causes me a problem to a certain extent, but I think sometimes it causes the staff more problems because what they would dearly love, and what I have always wanted to have is, if you like, a practice procedure, a practice policy for certain, you know, issues that come up and you cannot get all the doctors to agree, and they will not sign up to anything, they never have anything written down here, erm, and I never used to understand why, but now I do. It is because you then can’t point the finger and say well you said...And one or two of the receptionists have a great deal of difficulty in that, whereas the others will say OK, they are all different, we will just have to accommodate the differences’ (Female Manager 52).

In some cases additional difficulties were experienced by managers working in practices where there was significant ‘friction’ between the partners:

‘There is a bit of a perspective gap here and that is one of the problems with the friction between the partners. They all have a different perspective of what the others are doing. So in that case they have a funny view sometimes of what I am doing. I can see really that we need an away day to talk things through. There is a lot of friction there but they are wary of getting together in case they have a bust up and then the partnership will break up. So they are worried about that. We had one last March and they spent the first two hours discussing me and

then I joined them. I don't know exactly what they got out of it. It's most unprofessional they are like schoolboys at times, moaning about one another. It may help, it lets them get rid of the tension, but the staff don't like it because they have got four bosses and they are all trying to play one member of staff off against another. One doctor is the one with the bright ideas, some of them are very good but he doesn't see them through, unless the others support him, you are not going to get anywhere. You can have a strategic idea but you can't call it a plan unless you know you have the support to follow it through. I really doubt whether there is a long term future' (Male Manager 1252).

Difficulties did not stop for managers at the achievement of an agreed policy, since practitioners often chose to ignore such agreements in the course of their day to day work.

'You mentioned in your questionnaire that the partners tend to ignore protocols once they have been put in place?'

'It doesn't apply to them, that's right yes. I don't think that it's peculiar to me but one of the main frustrations of practice management and one of the biggest obstacles is the partners' subconscious feeling that whatever is agreed in the partners meeting doesn't actually apply to them. And although you bring a problem to a meeting and say "this is happening as a result of whatever, how are we going to get around it, how are we going to put it right", yes we will get a plan and that's perfect and they walk out, and this is the perfect plan to put the problem right, but of course it doesn't mean that they have got to stick to it because they are a general practitioner and they don't have to stick to anything. So it's not something that they do maliciously or spitefully or willingly even, it's just getting them to realise that they are part of the team and that a team can only operate successfully if we all stick to the agreed plans' (Female Manager 1295).

'They make systems and then they break them because it didn't suit them at that time and then we bring it up at a meeting. Then we make another system and it depends. Some doctors, if it suits them they'll go with it, but yes, we make systems and they don't stick to them' (Female Manager 1522).

This study would therefore suggest that the practitioner as opposed to practice led model of care remains strong in the UK primary care sector. Whilst incoming and long-serving managers may attempt to introduce a more 'corporate' approach to the delivery of health care this is commonly frustrated by the preference and freedom of GPs to do 'do things their way'.

SUMMARY

The importance of considering both macro and micro levels of analysis has been clearly demonstrated by the conflicting messages emerging in the accounts of managers, clinicians, policy analysis and literature on the professions. Analysis of the introduction of the 1990 contract and fund-holding in terms of both the political process and the content of the changes would suggest a radical shift in the authority of the profession to shape its status and rewards and control the labour process.

However, data at the micro level points to a continuation of professional freedoms to practice as independent clinicians within a 'company of equals' in which management supports, but does not direct, the provision of health care. Further, interviews found little evidence to suggest an 'internalisation' of management values on the part of clinicians at the level of practice. Thus whilst some GPs referred to the need to become 'more strategic' in the management of the practice, looking ahead to medium and long term development to meet the needs of the practice population, managers experienced difficulty in introducing, in some cases even the most basic elements of a more 'corporate' approach to service delivery in which partners worked to common operational and strategic aims, objectives and systems.

The impact of 'managerialism' has thus been found to be relatively weak regarding the organisation and control of clinical work, but what of the implications for the profile, identity and rewards of Practice Managers? These factors are explored in the following chapter which addresses the perceived identity of the 'new manager' in primary care and the implications for existing personnel.

CHAPTER EIGHT

MANAGEMENT AND GENDER

INTRODUCTION

As outlined in chapters two and six the practice management function has, until recent times, almost exclusively been undertaken by women. From the introduction of the 1990 GP contract male managers have begun to enter this field. The following analysis examines the impact of policy change on the 'gendering' (Acker 2000) of the practice management role using data from interviews with managers and clinicians.

8.1 Defining Management Skills

Interviews with managers and clinicians provided strong evidence of gender stereotypes with a clear association of women with 'soft' management skills whilst males were identified with greater authority, detachment and financial management skills. As found in other work, the value of skills was interpreted differently according to the gender of both the employee and employer (Linstead 1995, Threadgold & Cranny-Francis 1990).

A male partner summarised 'the difference' between male and female managers as follows:

'Well I don't know, I don't know why it is, it just seems to me I think they probably accept a decision made by a man sooner and feel less open to discuss it than sometimes they would from a woman. I suppose as well a man doesn't tend to get involved too much on a personal level with staff, which we have a very friendly staff, both doctors and the receptionists get on extremely well. But the women do tend, in fact men do as well, tend to share intimacies and gossip which sometimes when you have to come down fairly heavy on somebody it is difficult when it is someone you are involved with, a stranger coming in, and a man as well perhaps gives them a little bit more authority there' (1369 Male Partner).

The connection between women and emotion is clearly evidenced in this view, with the belief that a male manager would introduce a more 'detached' and 'authoritative' management style. The same view is expressed below by a female partner, who valued the 'emotional labour' (Hochschild 1983) provided by the female manager and associated women with superior communication skills:

'The majority of men are brought up, as an example, brought up to be asked a question to which they give their thought to and say we will do it this way or do it that way and you are supposed to do what they say. Whereas most women are much more inclined to see a lot of solutions and work through them, and so be less likely to impose things and more to consult about things. I think even now men are brought up to reach decisions in different ways and to view things in a slightly different perspective. I don't think you would have the same feeling (*with a male manager in post*) that there was somebody that we could all go to if there was any problem basically that would be prepared to sort of co-ordinate any views of that. I don't know whether a man would be more distant with the receptionists as well. I feel as though most people are prepared to go and say, "I'm not happy about this" to her. In a way that if it, a man might be seen as more distant' (Female Partner 1461).

Others felt the additional 'authority' introduced by male managers would be a welcome change in general practice:

'I think it's good (*males coming into practice management*). I think maybe, you know if they can get on with people, you've got a bit more authority there - it's easier on that sort of level' (Female Partner 1528).

Male managers were also associated with having a financial orientation:

'We had a male manager round in the other practice - he's now retired. They seem to be very financial, financially orientated. Every, all of them I've come across, I mean I don't know any of them as individuals, but you very much get that opinion. Perhaps they've been ex-bank managers' (Female Manager 1528).

'I think now there is more finance involved I think they are taking these ex bank managers and things - especially the fund holders seem to be going that way. I know one practice had a man and it was a total disaster, but whether that was his personality or what I couldn't say - I don't think you can - judge, it's very difficult. Obviously the partners that hired the man - that's what they wanted - was a man - there was a reason why'.

'So you think they set out to recruit a male manager?'

'Yes, I think so from the sounds of it they did' (Female Manager 1459).

'I think because general practice, primary care has gone so business oriented that a lot of people have thought ah, bring men into it, or men have thought this looks like a comfortable nice little job, and come into it then actually struggled with that side, or the people who have employed them have thought well they are very good at that but to the detriment of all of this. I think we have to get to a balance, so I think that they have brought different skills to it but not

necessarily better. But I do think that this type of profession is very much a caring and people sort of profession' (Female Manager 1530).

'I think we have come across quite a few (male) practice managers and they have staff managers and they are looking at it purely from a business and financial point of view, there is no patient element coming into it and no personnel element coming into it and it's performance related, and I find that a bit..., not my philosophy at all. So probably unfortunately the men we come across in the role are all that type and if we came across a practice manager who was doing the job like the whole section of the job I would have no problem with it, we would be happy to see it but at the minute it seems to be attracting a lot of ex-bank managers, who think it's a nice little financial job'

'Do any of them come to the Practice Manager meetings?'

'They don't, there is only one man who is a practice manager although we work very well on the fund holding side, he actually sends his..., I can't remember what her role is but she comes to the practice managers group which we find....we are delighted to have her and she works very well but we wonder why he doesn't come why does he think it's her role to come and not his. So that's something on his perception not ours' (Female Manager 1521).

'I know two practice managers who are men. I think I have got to say that they look after the fund holding side or have been employed to look after fund holding, so the one I'm thinking of at the moment doesn't seem to have a lot to do with staff and I know at one time things were in turmoil and he just sat back so I don't know if he had been a woman, it could have been the same. It's hard to generalise. I don't have any problems with men as practice managers - if they can do the job. But they are generally brought in for the finance and they are generally ex-bank managers. And sometimes I think what are they looking for when they employ people like that. I feel that they know finance but what do they know about quality within the health service. I worry a bit about that. We go to meetings and there are the men in their suits with their briefcases and it is dominated by costs all the time. I would like to see a bit about quality creeping in now and again, rather than just cost but because I don't know many men who are practice managers, I can't generalise' (Female Manager 1461).

Female managers alluded to the 'emotional labour' undertaken as a routine part of their role within the practice, extending to the support of patients as well as partners and staff. It was noted that male managers would 'set themselves apart' from such emotion, focusing on the 'hard' skills of financial management.

'They are more remote I think. I mean I see this with my colleagues at the meetings. They don't seem to be in the practices anything like as much, apart from the fact that they are out at a lot of meetings all of the time, they don't seem to, they don't get involved with the day to day clinical work (*claims, running reception etc.*) at all, which I do' (Female Manager 395).

‘Well sometimes they (patients) do ask for me. Like one rang just now. They just feel if they go to the top they get better attention, or they might be fobbed off by the receptionist, which is their job really. They can’t keep piling people onto the doctor, but there are some who think if they approach me then maybe I’ll be a bit softer- and I think I am. I think because I am married to the doctor, I hear a lot of things about patients and because he has a long standing relationship with them for the last almost 15 years - so he knows them from childhood, so he tells me and I get to know about their families and obviously I won’t know their medical histories and things, but I do get to know them, so I have an empathy with them. The others wouldn’t know that you see - they wouldn’t know that she has a problem, family problems. So I get to know them quite well, it’s handy’ (Female Manager 1527).

‘I took a course in counselling skills so I could handle staff and patients because the practice manager is in the front line, if you’ve got a complaint I’m the first person you contact. Also I find that in cases of bereavement I go and see people and I didn’t feel confident at handling it so I went on various counselling courses. I think that in a stressful job and the environment we work in you need to have somebody who is able to help people; I think it is very important’ (Female Manager 1087).

The following manager saw a direct link with her role in the home, where she felt the responsibility for managing family problems also lie predominantly with women:

‘I think you have also got to be able listen and read between the lines, I mean you might get a patient who is a little bit distressed and really they don’t want to speak to the doctor they just want someone else, I mean I often joke that my surname is Rayner, I can see on average four to five patients a day. I think they (*men*) would approach the job differently because they haven’t got, I wouldn’t say, the emotional ties when a patient comes and works on you, so they may set themselves apart from that, the ones that tend to come in are on the more fund holding side of it, they perhaps have a better head for figures, so I think they can switch off from one thing instead of having to worry about the personal side of things, is one of the girls having an off day because perhaps she is having family problems or whatever. Even at home a man can switch off, you can have a problem at home whether it be your own family or extended family, but you find that tends to lie with the women, not the men’ (Female Manager 1525).

The need to provide emotional support for staff was also voiced by other female managers as an area where incoming male managers fell down:

‘I had an experience a while ago which rocked me because I tend to think that you’ve got to look after your staff, give them a bit of time, and a comment was made by a male practice manager and I thought Oh Oh. They’d had a sudden

death in the practice and the nurses had been upset and he said, "That's their job - they're paid to do it." That hurt me because I would have approached it completely opposite. I would have gone and found somebody to help those girls get over the shock. So, that shocked me and I think males, we're all equals, I think they could make a good job of it, but I think they need to know a little more about handling people' (Female manager 1087).

A number of beliefs are identified as being associated with the 'new managerialism' in public services including, amongst others, a concern for increases in economically defined productivity, the application of communication technology and hardware and the perception of management as a separate organisational function which plans, implements and measures improvements in productivity (Pollitt 1993:2). In contrast to much of the available literature (e.g. Pollitt 1993, Ham 1997) Halford et al present a rare analysis of restructuring in the acute sector of the NHS which considers the gendered implications of the 'new managerialism' in its emphasis on the 'hard' management skills typically associated with male 'management styles'.

'Although there was still a lot of senior women in nursing, more and more men were seen to be coming in at the new managerial levels, and running through many of the interviews was the sense, if not explicit association that the values of the new managerialism were fundamentally masculinist ones, literally embodied in the new breed of male managers. In this type of account managerialism was linked to a preoccupation with masculinist values centring on the rational, quantitative, decision-making criteria of budgets. Nurse professionalism was contrasted to this through reference to more feminised values centering on the intangible, qualitative and relational criteria of a job well done by a nurse for a patient' (1997:98).

As in the acute sector, the 'new manager' in primary care is strongly associated with masculine skills, particularly financial management, leaving existing and incoming female managers with an assumed identity of 'the old style manager':

'I do think that the male managers are better rewarded than female. That really, if the tape wasn't going the word begins with P me off. This guy ... was on the course at the same time and I do have a lot of respect for him. He is in a big practice but his salary is massively over mine and even if I had a large practice I am sure I wouldn't be able to get a company car out of them and I sure I wouldn't get the salary he has got because I am a woman.'

'So you find you get less recognition because you are female?'

'Yes. Because we are viewed as the old manager.'

'Automatically?'

‘Yes. I know I could go to a bigger practice and get a higher salary and I am not cribbing about that. What I am saying is that I couldn’t get the rewards that a male would in the same situation. I am well paid in a small practice’ (Female Manager 1352).

Whilst existing managers emphasize their experience, communication skills, understanding and affinity with the ‘caring culture’ of general practice, incoming male managers sought to undermine this position by emphasising their experience of ‘real management’ in the private sector:

‘Now if you go to some of the practices I cannot imagine some of the practice managers I know being on a level of strategic thinking where they could go to the Department of Health and discuss the setting up and commissioning for a service for epilepsy in primary care. Now this is a small area, now start to multiply that outwards and it the locality becomes not just pertinent, but locality commissioning becomes more and more important, it is natural evolution..... One of our biggest crimes of course is stuff coming from secondary care to primary care and the resources aren't there. If you like *your old fashioned* (author’s emphasis) practice manager doesn't take that into account, *she* doesn't see why, I use she because you will find that there aren't many male practice managers around, there aren't many coming this way round and would recognize that as a strategic problem. And that's a problem they are going to have get these skills otherwise these small practices will get gobbled up they will be left with signing sick notes, and there are some practices that survive like that’ (Male Manager 48).

Language was a key factor in the linkage of existing Practice Managers with a housewife/housekeeping role, with reference to ‘wee wives’, ‘little people’ and ‘the girls’ and a clear demarcation between management and administration, the latter being the function of females:

‘Obviously there is a clear difference, normally speaking most females would work at the admin. level and find it difficult to work beyond that, having said that I do a lot of finance work which is administrative but...’ (Male Manager 1254).

The comparison of two views on the professional Association of Managers in General Practice clearly illustrates the ways in which language was used to undermine existing practice and assert a ‘masculine’ image of the management role in primary care:

‘I went to a thing produced by people in London who were talking about future practice management skills still needed within that, and they were running this

practice management and NVQs course, I wouldn't even consider it, because the people doing it were worthless people like that and they have an association, they are all for the Association of Practice Managers, but what we are actually talking about is a group of managers who are directing and managing primary care. There are still lots of practice managers today who think they are part of the health service, they are not they are part of health care, for various reasons. It is terribly difficult, I meet plenty of them around, I don't tend to go to the practice managers' group (pulls a face) They are a very well meaning bunch of people, I have been along a couple of times, I have just thought this is not my style, tea and cakes and a lecture on lasectomy doesn't mean anything to me, I don't have any interest in medical verbalage, what I am interested in is how do we deliver health care and nobody is talking about that. Now you see you need managers in general practice who are going to be talking about how do we deliver health care, not how they are going to manage the accounts the next day' (Male Manager 48).

'Unfortunately, I am not quite sure it is unfortunate, but I think that you get some people, particularly men, come in to general practice and still see AMGP as this traditional knitting circle type thing, twin set and pearls, that any meetings are held over coffee and discuss either the kids 'O' levels or what they were doing at the bowling club the other night. It is not like that at all'. (Female Manager 1530).

Reference to domesticity is thus used to link women back to the private family sphere and re-assert 'masculine' values and modes of acting as the essence of 'management'.

Apparently neutral appeals to the superior qualifications and experience of incoming private sector managers served to undermine forms of human capital linked to existing female managers such as an internal career path within general practice:

'Well obviously there are perfectly competent women managers how could I say anything different from that but I think the great benefit of more men coming, more men have been managers in the past so out there, there are more good managers who are men than good managers who are women. But that doesn't reflect the competence of women that reflects the structure of management really'.

'So there is a larger pool of good male managers?'

'Yes I just guess that is the case. Financial service industries have shed bank managers in huge numbers over the past ten years, and by and large they are a generation of plus fifty year olds and by and large they are men so in so far as sex is anything to do with it, there is now a group of people out there who are skilled managers and they have become available to GPs to recruit' (Male Partner 1262).

'The only difference is because of the history because most of the women that are in it have probably come up through the receptionist route and they approach

it differently from that point of view, not because they are women but because of their previous job’.

‘So their previous experience is the important factor?’

‘Yes, there are one or two fund managers who are women who would come into here and do the job exactly as I would’ (Male Manager 1262).

‘I think on a straight management basis I don’t see why there should be any difference, to be honest with you. I think what is perhaps more relevant is the fact that the men that are coming in have not been involved in medical practice administration on a lower level, by and large, and so they’re coming in as managers because they’ve got management experience elsewhere. Now I know some ladies in this area who have also gained management experience outside the medical area and have come in as practice managers and are doing an equally, if not a better job. So it’s really the level of management experience or skills in terms of who is going to be able to do the job’ (Male Manager 1077).

What all these comments have in common is the association of internal promotion within general practice as being an inappropriate route to ‘real’ ‘professional’ management. This serves to reinforce the distinction between ‘old’ and ‘new’ managers and does not question the reasons why men outnumber women as managers in the private sector. As chapter six identified, three out of the seven managers identified as operating at a strategic level within the practice were in fact promoted from within general practice. Furthermore no apparent gaps were found in the proportion of male (2 out of 13, or 15%) and female managers (5 out of 27 or 19%) operating at this level.

The enhanced managerial allowance introduced as an incentive for practices to adopt the fund-holding initiative was also seen as offering the career structure and rewards demanded by male managers: the assumption being that women did not seek or require such a structure:

‘In the past they weren’t available. Now, the managerial structures in health care, the opportunities available and the salaries available actually, and the challenges available would tempt a lot of men to apply. I think that is why you are getting more men, you know, there wasn’t a career structure before’ (Male Partner 1254).

In commenting on the entry of male managers to primary care, the following female manager reflects on the depression of salaries linked with the concentration of women in the sector.

‘If you were a breadwinner, you would be in business, you wouldn’t come here and take a great drop in salary; really, I mean that is what you would be doing. Now some of the practices pay extremely high salaries, which I know about. We know, it is all published in the thing. Here they put them up gradually, they are not quite what they should be, but you know, I am sure the next person that takes my job will want more’ (Female Manager 395).

The language of managerialism and the actions of incoming male managers thus served to define women as a ‘class of ineligible’ in the new primary care arena.

8.2 Human Agency

That women were aware of moves to undermine their position and also sought to actively re-assert their worth is clear from interviews with managers. Some managers identify consistent and established inequality between the sexes as having a direct impact on their experience of work:

‘I think a couple of them, the younger men funnily enough, I wasn’t really what they wanted I wasn’t a distinguished looking army type in a pin stripe suit, so I had to work quite hard with them they kept treating me like an additional secretary and I did tell them that if that’s what they wanted financially they would be far better off to get 2 secretaries. It is a very sexist organisation to some extent, men are the doctors and women are the receptionists and secretaries, it’s breaking down a bit because we have got a couple of women doctors now, they are not raving feminists in inverted commas but they are quietly assertive and well why, you know you get the coffee if you want a cup. But it was and I think the staff specifically had a problem with me because they were told that they were getting a manager and it would be a man, to start with. One member of staff said to me “you have really put the wind up a lot people Jane because when we were told we were getting a manager” and a lot of them thought that they would get this pin-stripe distinguished looking chap who would walk round now and again like the doctors do and say “Oh well done” and instead they got this women in a woolly pully saying show me what you do, how many times do you do that. They didn’t expect someone who would come in and look at things. There has been some kind of almost unwritten advice to GPs when they are looking for managers, look for ex-army offices, ex-air force managers’ (Female Manager 1295).

The following manager identified with the real and enduring status differences associated with horizontal segregation (Hakim 1979), noting the benefit of a rise in status following the entry of men into a previously 'female' sector:

'I welcome the appearance of them (*men*) from a strange perspective it suddenly gives the practice manager a better status.' (Female Manager 1352).

The diversity of women's experience was emphasized, reinforcing the importance of avoiding 'essentialist' analyses which infer homogenous categories of 'men' and 'women' and in so doing mask the agency of women in challenging cultural expectations of their role:

'When I first started here I had a meeting with one of the partners who said "of course the staff don't want you here, they don't believe women can manage". Also if you imagine a group of women coming from an ex-mining town, a lot of people here have never been beyond Newcastle, they don't go on trips to London, I am sure the staff do, but the general culture here is one, quite intense, extended family relationships. A woman coming in from a very broad minded background, with a lot of management experience, the culture shock is quite difficult, and I think they have difficulty with me, how I am female and how I regard myself as being a woman. Women here are, they lack self esteem, we have huge examples of appalling self esteem and abuse at home by their fathers or husbands, just treating women in such an awful way, a lack of self respect, a lack of belief that there are careers open to them or a life outside xxxxxx, and I think in terms of gender, they have great difficulties with that. And I have had to say things to them, if we don't believe in ourselves as women and if you condemn me for being a woman manager then we are really damned. And I have actually said that to staff. My god, what the hell is this and possibly I am on a one woman crusade to enlighten the people here, because if I don't do it right now in my day, they will go back to saying men can manage because they are men, paternalistic models, controlling models, subjugation of women, they are comfortable with those models. That is a specific example here. I think that gender matters everywhere and that there are different perceptions about men and women, and it shows more the less competent you are. So I think, it is the old cliché, if you are average as a woman, your womannESS will show more than if you are superb. Depends who you are dealing with as well, a lot of men feel threatened by professional women..... I have felt the benefit of, having been lacking in self-respect and subjugated and abused and misused and very low at one stage in my life, and I have worked up from that. So I have seen the changing views of people, I see me, and I have actually perceived shifting from being someone who you could disregard, to someone who people are actually quite afraid of, men are quite afraid of, that is quite a strange shift' (Female Manager 1398).

The career history of a manager on the verge of retirement also illuminates active agency within the constraints of structural inequalities. Having been blocked from taking up a management career in banking following the birth of her children, Eileen worked within her husband's business and then entered practice management. Prevented from pursuing her original career ambition, Eileen then perceived a threat to her current post in the form of ex-bank managers recruited to deliver the requirements of fund-holding in general practice. Eileen responded to this challenge by pursuing formal management qualifications, a means, in her words, of 'staying one step ahead':

'When I was practice manager I was on a very ordinary salary and I did various exams and went to open University and then fundholding came along and there were practice managers being brought in from nowhere who, from a banking background, who hadn't done anything in connection with fundholding but had a banking background, and this irritates me when they say you know so and so's got banking exams and background, well so have I but the years ago when I was in the banks they didn't make you bank manager but if I had been a man I would have been a bank manager. I have two sons that are grown up. What happened when I had mine was I worked in a bank, I left work. I wanted to go back into the bank and the manager wanted me back but they would only let me come back part time and I wanted to go full time'.

'So they didn't give you that option?'

'No, not in those days. And my husband had his own business so I became involved in that. So I have these qualifications. And I felt all the way through I did this open university unit, part of the MBA, managing health services, just the very start of it but I did that to keep one step ahead of all these bank managers and accountants that they were bringing in. And I had to when we first went fundholding, I had to fight and say well hang on these people are being paid twice what I am being paid and I feel you know, and that was it they were very good about it. And then in latter years I think they began to realise that if they wanted to replace me they have got to have a proper salary structure in place to attract someone. You need the money there to pay them. So I think that was another incentive for them to push my salary up. I don't honestly think that the receptionist route up to practice management is a good idea. I think you have got to have something, the way practice management is now you have got to have something a bit extra. I have peers that are both male and female and I respect both. I think in any walk of life it is still I am afraid male orientated management and a woman has to be just that little step ahead. I am sorry to say that but it is true. I have tried to stay one step ahead, when fundholding first came in all these new managers came in who, and everything was wonderful and everywhere anybody turned it always seemed to be these men that were getting involved in things, not only just me there were two or three other women that were saying now hang on a minute you know just because they are a man, and I think now it is turning around a little bit and they are beginning to realise that they are not necessarily better managers'.

‘So you think fund-holding had an influence.. ’

‘Men wouldn’t have come into just general practice management, the odd one or two would have done, don’t get me wrong, I mean I do know the odd male receptionist, but the actual high flyers have all come in when fundholding came in, accountants and bank managers. I think they thought it would be a nice little job and it’s not. There is great deal of uncertainty and stress’ (Female Manager 1377).

Incumbent female managers in practices where male managers have been introduced have fared less well. Whilst some have been allocated ‘specialist’, usually ‘HR’, functions, subsumed within the overall control of an incoming male ‘General Manager’ others have been made redundant or taken early retirement:

‘The structure as I say is myself at the top in the number one position and then immediately below me is Janet the practice manager who, as I said is part time and has the day-to-day responsibility for the practice and specifically for staff. But certainly it has been necessary over the first year to establish that that IS the relationship, and now we work quite well together but it had to be made quite clear that I was first and practice manager was second’ (Male Manager 449).

‘The structure that it is here now is new. Prior to my coming this was not a fundholding practice and there was a conventional practice manager here, she left, I was appointed as fund manager, for various political reasons she left when I was appointed. And I was then asked to take on the management of the business side of the practice. So that was when this dual management role was set up’ (Male Manager 487).

‘Do you know the background of the previous manager?’

‘Health service, pathology, laboratory assistant that type of thing up to the management change, previous practice manager was receptionist, senior receptionist, practice manager’

‘So she has actually left now?’

‘She has gone, she was made redundant’ (Male Manager 48).

‘You mentioned there was a manager who left?’

‘It was a case of what you often see in all industries I am sure, when that particular person was appointed general practice was in different circumstances, a very different ball game, in the advent of fundholding she realised that she couldn’t cope, we appointed the new manager *to deal with the finance side and by definition that was a more senior position, (author’s emphasis)* which she found stressful, in actual fact, at the end of the day she retired’ (Male Partner 1254).

‘We had a period where we had a practice administrator who we had problems with, problems because she had been with the practice many years and wanted

to continue the job. She left. It is only recently we have actually appointed a practice administrator'.

'What does that role entail?'

'I am responsible for them all at the end of the day, everything, but the running and day to day running of the business is left very much to people such as the line managers. It is up to them if they have any problems to come to me' (Male Manager 1254).

Some managers accepted or at least presented the 'difference thesis' at the level described by Acker as 'individual identity and presentation of self' (Acker 1990), but challenged the status applied to their skill set and sought to undermine the male position by appealing to the better fit of their skills to existing cultural values in general practice.

In so doing this served to reaffirm the 'difference thesis', a strategy which as Callas and Smircich (1993) point out, can be of limited benefit to women in restating traditional management approaches which de-value women's contribution. Further in the context of organisational change the appeal to existing cultural values also served to reinforce incoming male managers' identity as 'the new breed', injecting energy and enabling practices to meet the challenges ahead:

'I think it is all really changing, you can talk to the *girls* here, I am quite happy to go and talk to the *girls* here, the culture change in the last five years has been tremendous, The previous manager was here 20 years, everything was neatly done, what she said went, she had a finger in every pie, and everyone's business and so on and so forth, she managed to run the practice accounts, fine, but there was no sort of how can we be entrepreneurial little bits, you know, what can we do that is slightly different how about we get the reflexologist in, and things like this. It didn't exist, and because, the fund holding is a lot responsible, because it tended to bring in people from outside, it brought opportunities. Now if you don't find the change exciting you are not a very good manager in health care at the moment, how are we going to deliver health care and how will the staff play in to that. And that is what we look at, what are we going to deliver, how are we going to do deliver it, where is the need, *right guys* let's go and get it, now how in the hell are we going to get all the staff, and we do it. But that is my philosophy, and it is the philosophy of the partners here. The philosophy is how are we going to run the health care here, goes all the way down, ... what is the best way to do this, how can we adapt, how can we deliver the changes' (Male Manager 48).

'I think in a way I think that when I look around the area and you see the calibre of people managing practices I think there are one or two characters round about who I think in a way have an over inflated opinion of their status, and make sort

of big noises and you know, maybe at the end of the day if one had a chance to look into their practices you could probably sort of make, lots of beneficial changes. I would certainly think that in the future that it is a very good opening for males, and females too, but I think the traditional method of coming through the practice, there will still be room for those sort of people probably in the smaller practices but I would imagine for the future that the management of larger practices will need people who have had *proper* commercial training in their earlier career and I think the job is becoming more professional and greater skills will be needed for the future so I guess that is where you have the emphasis on previous training coming into it really. So I would still see that there will be a large number of *ladies* running small local practices but I also think that the number of males will increase and the present imbalance will even itself out in time but it may never be 50/50. But I certainly see the numbers of male managers in general practice increasing as time goes by' (*author's emphasis*) (Male Manager1455).

'I think that probably the greatest difference between the two bodies of people is that the women, who are in place at the moment largely, not exclusively but largely were promoted to the ranks, started as a secretary or receptionist and were promoted. I think that still the majority of general practices have promoted people who have come from within their own organisation. And therefore it is going to be biased against men because there aren't many men who work as secretaries in general practice. So the men that are in the place *have been introduced as a change as a new direction and a way of stopping internal personal rivalry within the show, and that sort of thing so I guess a lot of men have been brought in as part of the practice's concept that "We are going in the new way now, we will try this"'* (1377 Male Partner, *author's emphasis*).

Speaking of the entry of male managers to general practice, the following respondent again links males to a 'new, dynamic' role:

'There are more and more fund holding practices now, as the criteria for entering the scheme was recently changed, and what is happening I have found in some practices is that the *old style (author's emphasis)* promoted practice manager, is staying in her job and being brought into work alongside her is the *new young, dynamic fund manager (author's emphasis)* who has the skills that she hasn't got. Maybe the accountancy skills. So, it will work in some practices, it may not work in other practices. It is difficult to be prescriptive because it all depends upon your partners and what kind of a role they want to play within the management structure' (Female Manager 1382).

The work of Witz (1990) is of value here in distinguishing between a range of strategies to achieve entrance and reward within a particular occupation. As outlined in chapter four Witz adapted Weberian concepts of occupational closure in distinguishing a number of 'gendered strategies' employed in attempts to establish 'professional projects'. Whilst applied to the development of the medical and nursing

professions, her theories have a wider application in explaining the ability of occupational groupings to define and defend the boundaries of their membership and the scope of their remit.

Witz defines a number of 'gendered strategies' including exclusionary, inclusionary, demarcatory and dual closure strategies. Exclusionary and demarcatory strategies are employed by dominant groups to exclude subordinate groups from opportunities and rewards in the case of the former and to create and control occupational boundaries with related occupations in the case of the latter.

'A gendered strategy of exclusionary closure is one which is exercised by a dominant social collectivity, men, which serves to create women as a class of ineligibles. It secures for men privileged access to rewards and opportunities in the occupational labour market'. This strategy employs gendered collectivist criteria of exclusion vis a vis women and gendered individualist criteria of inclusion vis a vis men' (1990:125).

Responses by subordinate groups can take the form of 'inclusionary' strategies where the aim is to gain access to the opportunities and rewards denied or 'dual closure' strategies where subordinate groups seek their own professional project via registration and credentialing for independent occupational areas.

Whilst the emphasis on formal credentialing and registration is inappropriate in the context of practice management, the theory is of wider application when applied to less formal means of establishing 'eligibility' for membership of an occupational group. Thus incoming male managers sought to define women as a 'class of ineligibles' for the senior management positions opening up as a result of the new contract, on the grounds of their lack of qualification and experience in 'real management positions'. Women have sought to counteract this by employing 'inclusionary strategies', voicing their right to be considered on an equal footing with male managers, and dual closure strategies where men are defined as 'ineligibles' on the basis of their differing skill set which is defined by women as more appropriate to the private sector.

8.3 Organisations As 'Stores of Past Agency'

The distinct 'culture' of general practice is constantly referred to in interviews with managers; a clear link between organisational culture and the identity and role of managers is voiced by the following respondents, who identified a more 'family orientated' culture in general practice which was more 'suited for females', emphasising the ongoing link with patients and the concentration of female employment in the sector:

'I think a woman is more suited for the practice manager's role. I think managers should stay in hospitals - NHS - men should. I think it's more suited for females. The bulk of the practice is staffed by females. I think one man can just set them off. I just don't think they fit in. I think it depends on the man, but I think on the whole, women are better suited for the practice manager's role, I think in the NHS in hospitals they do fine. I think it's because it's such a caring profession and you are dealing so much with patients and quite a lot of them are family orientated. I think women are more family orientated, more so than men. I think (*in the hospital sector*) most of them sit at desks and do administration' (Female Manager 1527).

'I have heard about male managers. I think that normally they come in via sort of bank, or services or something like that. This sounds sexist really, but I don't think that they always have the feeling for the job that the girls do, but I haven't had, I haven't directly worked with a male manager, so I don't know'.

'So when you say the feeling for the job can you just explain..'

'I think that if you have worked in general practice before, you do have, you do get to know the way it works and you do just have that in-built reserve of knowledge. Whereas someone just coming in thinks they can just run it like any other business, and although it is run as a business to an extent because the partners are in it to make a living and the staff make their living through working in a practice, I think that you can't look at it like being a bank manager, because the patients are not like people that go into the bank and pay their money over and ask for over-drafts and things, you are dealing with the patients and their health and I think that is a totally different type of thing to just any other type of business. I just feel it must be because I think nothing is more important to people than their health and I just feel that it isn't the same as working and you can't be so ruthless as I think you can be in general business terms. I think you need a better appreciation of the concerns of the patients as well, I feel that rather than seeing that as a business, I don't like this idea of calling patients clients or customers. Maybe I am old fashioned but I like to think of patients as patients' (Female Manager 1376).

'I know a lot of bank managers, men, who have come into practice, I think it depends upon, I think that the practice has got to decide upon the sort of culture that they want. And I can only speak from personal experience, but I do know

about five bank managers who are working. I also know a couple of girls who have come in from outside, and I know a couple of girls who have come in from the hospital sector. They have a very top down style of management, very chief executive sort of style, 'do as I say', that isn't me. Erm, my ultimate aim is that through training or whatever, delegation of skills, building trust, I could come in and do no work in a day and have everybody else do it for me I don't particularly want to retain anything for power reasons, and, it just, it, I suppose it is horses for courses, a practice has got to decide what they want, and go for it. And we have a very open communication sort of system here, all the partners are involved completely in what goes on, we all know what each other are doing. I think sometimes in a more top down style of management, sometimes the partners have a tighter remit, they are not perhaps so involved. I think you find the culture that suits you, and that is what you go with' (Female Manager 1382).

References to the distinctive nature of general practice support recent developments in the field of organisational studies to adopt an 'embedded' approach to organisational analysis where:

'Organisational structures, practices and cultures are devices by which past forms of agency are in a sense 'stored'. In as much as structures practices and cultures remain constant, the effect of past agency is continuously reactivated, and even where change takes place it is on terrain defined by previous 'organisation' (Halford et al 1997:18).

Thus organisations are not 'depersonalised systems' (Halford et al 1997:15) driven logically by the singular pursuit of increased profit and efficiency. Rather, general practice as it is today, is saturated in the past agency of a 'professional project' which sought to define and claim an area of work as unique and subject only to the control of those sufficiently qualified to understand and implement it. Thus it is the agency of the medical profession which has established health care as distinct from other service occupations, grounded in paternal models of care where the qualified practitioner 'knows best' and the recipient is a 'patient' and not a consumer of services. The language of managerialism and markets sits uncomfortably in such a culture, a point which is explored further below.

8.4 Culture Clash?

Another crucial factor is at play in re-defining the practice management role: this being the response of physicians to the 'new breed' of practice manager. The 'caring

culture' identified by female managers is underpinned by the principle of clinical freedom: the 'right' of individual clinicians to manage and practice medicine as he or she sees fit in the best interests of the individual patient. As analyses of management roles have illustrated, in spite of concerns over the operation of the new contract and the management of fund-holding, GPs are generally reluctant to hand over independent authority to managers with few genuinely seeming to seek a truly 'strategic' management function. Thus the 'masculine' approach of the 'new breed' of manager may not rest easily within a 'company of equals'.

Frustration with the ability of clinicians to operate independently and outside of agreed organisational practice is reported across interviews with male and female managers. 'Freedom to manage', a core principle of the 'new managerialism', was very much determined by the will of the partners and in some cases this had led the 'new breed' to leave.

'Perhaps they would push harder than women, particularly coming from outside. A lot of men are leaving the armed forces with sizeable pensions and they're coming into general practice and I've heard they are far more aggressive in their approach, to what they'll stand for and they have better negotiating skills, but how well they fit into the culture and how long they last remains to be seen. I have heard that some of them where people have come out of the forces and they've lasted only a year or two simply because of the culture. It's a very cosy, friendly culture, very family way of doing things. They have been in the army after all which has a very regimented environment, the opposite of general practice; it's a big change for them. Doctors don't seem to know what a policy is they are a law unto themselves. By the very nature that they are men (male managers) they will push harder and they will be more forceful and they will want to come out winning and women, may be for the sake of peace and for the sake of - perhaps for the sake of decency she'll go so far and that's it, whereas a man will push for as much as he can get' (Female Manager 1323).

'I don't think I have come across many male managers who have actually survived. I know one chap who recently left because the partners wouldn't let go of the strings to allow him to manage. He quite obviously had the ability. He had chosen a practice that didn't want to release the whole' (Female Manager 1352).

'I would say to somebody who's coming in from the outside, like a bank manager, is you better be able to understand your staff and their needs in general practice. I know there are bank managers coming in, and I know there are bank managers who leave. They're bringing very special skills to the job, but possibly

dealing with a lot of women is not one of them. You see this is a very close knit type of a job, slightly different - it's not like working in an ordinary office - you rely totally on each other and communication is vital' (Female Manager 1372).

'I have thought about it quite a lot. I sometimes wonder if it's because - I mean it's often the big practices that bring them in (male managers with forces background) and it tends to be the practices who have, they have had the longer term receptionist who used to be known as the dragon at the gate, and I don't know, I just have this theory that the doctors think if they bring in this army or naval type person they're going to be a strict disciplinarian and bring these girls to heel! It's totally wrong of course. Unfortunately it doesn't always work. I think a lot of problems stem from the larger the practice; I mean doctors are notorious for making decisions. They cannot make a decision. I mean it is not like in a company where you have a managing director or chief executive and then it comes down in a pyramid. It is sort of leaner and OK we're all looking at leaner and flatter organisations, although it's leaner you've actually maybe got eight chiefs and they all want it in a different way and so to get a decision on things is a nightmare at times. It must be very frustrating for somebody who's been in a service situation where disciplines and hierarchy is very strict; you don't cross the boundary lines' (Female Manager 1352).

Again female managers drew on the 'difference thesis' to emphasize their interpersonal skills, enabling them to 'deal with' partners in a 'less direct' manner and thus 'fitting in' better with the existing organisational culture:

'When I first came for the job, they took on a man, who I think had the same ideas as me but didn't have any personal communication skills, and it was as simple as that. He came into post, I was interviewed at the same time as him and got a phone call to say sorry you have been pipped at the post, in some ways it was relief, because change is dangerous and I was safe where I was, I could of stayed there. They took him on and he lasted six months, he had ideas and as I did, just went ahead and did it but he made them feel that it was nothing to do with them, it was his job, he was the manager and that was it, you had to stick to your ranks, he was ex-army. It was alien to them. When I first came here I used to be treated like god, (by staff) now I'm just one of them. So he ended up leaving, they placed too many restrictions on him so he walked out. And then they rang me up'.

'A lot of the male managers I have interviewed have had a forces background'

'Doctors seem to be very impressed by that and then they can't handle them. I think they think they will get someone who can instil discipline but is also used to taking orders and will only do as they are told. The ones I have met, that's not quite the way it works. There is a certain level in the army where they have a lot of autonomy in what they do, and at the end of the day you always have the doctors to answer to. *I think it needs women to put up with it actually*' (Female Manager 1361, *author's emphasis*).

SUMMARY

As Walby notes:

‘The analysis of points of change offer particular insights into gender relations in employment (86:91).....changes in the organisation of capital often precipitate gender struggles over employment in particular occupations, since they both destabilise the old balance of gender forces and create and destroy particular forms of employment’ (86:88).

In this particular case, the agent of change is not capital, but the state via the introduction of a new working contract for general practitioners and an internal market in health care. The calls for improved ‘management’ of health care and in particular, the introduction of an internal market has raised the profile of management positions in both acute and primary care sectors. Unlike most of the existing analyses, the current focus was on the impact of these changes on management in primary health care and those working within it.

The data presented here clearly identifies ‘gender struggles’ within general practice at the time this fieldwork was undertaken. Whilst still few in number, the entry of male managers was clearly having a significant impact on the profile of practice management and the position of women in the sector.

The fund-holding initiative raised significant concerns regarding the suitability of existing arrangements for financial management, alongside the new requirements on general practices to plan for the health care needs of their population. The language of markets, targets and strategic purchasing of health care services was seen to equate with the ‘masculine’ styles of ‘professional’ managers to be found in the private sector, with incoming male managers claiming their identity as the ‘new breed’. In this discourse women are characterised as the ‘old style practice manager’ unable or unlikely to keep up with the new demands on primary care.

In recognising the threat from incoming male managers, women can be seen to have adopted two strategies: ‘inclusionary’ strategies where women defend their right to be valued on the same terms as men, seeking formal credentials for their experience and emphasising an equal skills set, and ‘dual closure’ strategies where female managers

sought to under-mine the 'new management' discourse by claiming greater affinity with the existing culture in general practice as a 'caring organisation'. In emphasising the 'emotional labour' and 'people skills' they offered the latter strategy could be seen as reinforcing the claims of male managers as the 'new breed'. This work would suggest, however, that the success of the 'new breed' discourse will ultimately be determined by the outlook of partners, who to date have controlled the labour process on the basis of the occupational principle where:

'.... management does perform logistic functions, but is essentially stripped of what Weber considered to be the prime characteristic of administrative authority – the legitimate right to exercise imperative coordination' (Freidson 1973: 24).

Analysis of the actual roles of managers demonstrated that the 'new breed' was most likely to focus on the financial side of the practice and the management of the fund. Managers identified as genuinely operating at a 'strategic' level, involved in determining the direction and development of the practice, were few in number and as likely to be female managers promoted from within the practice as male managers recruited from public or private sector management.

Interviews therefore revealed the complex development and articulation of gendered identities within work, supporting the conclusion that 'gender differences' are socially constructed, being negotiated and contested at work and constructed and reconstructed in social practices (McDowell 1997, Acker 1990).

The following chapter draws together the analyses presented and offers a theoretical framework for understanding the dynamics at work in primary care in the 1990s.

CHAPTER NINE

POWER IN PRACTICE: EXPLAINING CHANGES IN PRIMARY CARE IN THE 1990s

INTRODUCTION

It has been noted that the key challenge in this work was the need to draw together insights from a disparate range of academic disciplines to provide a holistic analysis of change in primary care that reflected the reality for participants, as opposed to the narrower fields of specialism brought by individual investigators. Key disciplines have been identified as:

- Contributions from the study of professions and expert labour that have demonstrated the ways in which professional workers have established a dominant position within the labour market which enables significant control over their own labour process and that of other occupational groups
- Analyses of policy change which have offered theories of the motivation and intent of policy makers in their challenge of professional powers
- Studies of managerialism and management which illuminate the conflict between professional and managerial values
- Contributions from the fields of gender and organisational studies which, particularly in recent times, have brought the identity of the worker to the fore in analysing the ways in which occupations become defined and controlled.

Research undertaken with clinicians and managers in general practice has indicated a complex picture in which the authority of professionals is both challenged and reinforced, and where the meaning of 'management' and 'manager' is negotiated and contested with implications for the gendering of the practice manager role. The experience of working within general practice is thus multi-faceted, shaped by the influences of gender, class and the state. Whilst much of the existing literature addresses some of these elements, few theories adequately account for the interaction and relationship between all dimensions identified. The following chapter look at how

these insights can be drawn together to provide a means of understanding and explaining the dynamics at work in general practice at the time of this study.

9.1 Capital and the State

Much of the theory in relation to declining professional powers has been developed from the neo-marxist perspective and specifically to theories of a process of 'proletarianization'. Emerging principally from the United States, the increasing involvement of multinational corporations in the health care sector, has, it is argued led to a shift from independent practice to the mass employment of physicians, paralleling earlier transitions of craft workers to the factories in early industrialisation.

This work has challenged the validity of the proletarianization thesis, drawing on the significant structural differences of employment relations in UK general practice where the majority of practitioners are independent contractors to the state; being small business owners within partnership or sole trader organisational structures.

It is recognised however, that as monopoly purchaser, the state has significant power to determine the exchange of goods in the market place for health care, where the collective professional bodies negotiate in the manner of trade unions to protect the interests of their members. Characterised as a 'bargain' (Klein 1995, Moran and Wood 1993, Rivett 1998), the relationship between the state and profession has demonstrably shifted during the period under study, with the imposition of a new contract for GPs introduced against the will of the profession and motivated, it is argued, by a 'new managerialism' in the public services, inspired by practice in the private sector:

'The managerialisation strategy did not spring fully formed from the hydra head of new right think tanks or the Thatcher cabinet. It draws on a set of analyses and prescriptions which were developed about the failings of the American economy in the late 1970s (Clarke and Newman 1993:51).

Indeed the private sector is emerging as an increasingly important component of the health care system in the UK, where state funded services are increasingly being out-sourced to private sector providers. However the economic reductionism underpinning the proletarianization thesis fails to accommodate the complexity of

power relations in the UK health care system, where the state is identified in this analysis as the primary agent of change, motivated not by a desire to achieve 'profit' but to control and ration public spending whilst maintaining public office.

It is argued here that the state may adopt the practices and at times serve the interests of capital, but is not reducible to it, with the former being the main catalyst of change in the UK NHS as compared with developments in the United States where capital has assumed a more direct role. The importance of situated analysis is therefore emphasized in this work.

Analysis at policy level supports theories of a 'new managerialism' in public services, linked with the 'New Right' or 'Neo-liberal ideology of the primacy of free markets seen by Bradley as:

'The attempt to reconstruct work relationships and social identities in line with the principles of meritocracy, competitiveness and market primacy, establishing much more firmly the hegemony of capitalism and stamping out the socialist 'enemy within', has been a crucial legacy of the Thatcher epoch' (Bradley 1999:219).

Thus public services have been portrayed as inefficient and expensive monopolies, led by professional interests as opposed to citizens' needs (Harrison & Pollitt 1994). The introduction of an internal market in health care placed the GP as 'proxy consumer' determining the health needs of local populations and, along with Health Authorities, purchasing services to meet identified needs.

Analysis has identified the dual processes of fragmentation and centralisation, creating purchaser and provider roles and devolving decision making to local level whilst increasing surveillance and control in the form of outcome measures and performance targets from the centre. This echoes critical analyses of 'post-fordist' forms of production, where it is observed that perceived shifts away from bureaucratic forms of management control in the production of mass-produced goods to more flexible organisation structures and working practices are matched by increased surveillance and control at the level of the individual (Burke 2000, Halford et al 1997).

Fund-holding thus offered GPs the 'additional' authority to purchase a range of defined services for their patients but introduced, for the first time in the history of the NHS, a capped budget which imposed accountability on GPs for the financial implications of their referral decisions, explicitly involving GPs in the rationing of health care.

Whilst this thesis rejects the concept of the 'proletarianization' of professional workers, it is argued that capitalist philosophies have been evident in the approach of the state to the reform of public services in the 1990s, aimed at reducing public spending and increasing accountability for the allocation of resources. What analysis at the policy level has failed to fully address, however, is the actual impact of these strategies at grass roots level, the main focus of this thesis

9.2 Gender

The implications of 'managerialism' for the gendering of occupations in the public sector has been largely overlooked in Neo-Marxist and policy analyses, where the focus lies on relationships between classes and/or the state and professional occupations. Thus in spite of almost half a century of feminist study it would seem that the analysis of gender is not yet an integral element of 'mainstream' study.

Whilst the impact of policy change on the freedom of professionals to control their labour process has been identified as limited in this thesis, the impact on the profile and rewards of managers in the sector has been significant.

The language of managerialism and the increased rewards made available via the fund-holding initiative have 'destabilised the old balance of gender forces' (Walby 1986:91) and precipitated gendered struggles in the definition of the practice management role and identity. Incoming male managers have sought to define existing female managers as a 'class of ineligible' in the new arena of primary care, whilst women have sought to defend their position using a range of gendered

strategies including appeals to equal skill and status and the distinction of a differing skill set which is more appropriate to the culture of general practice.

9.3 Structure and Action

With its emphasis on human agency, diversity and situated analysis, the research presented in this thesis does not support the concept of static, self-sustaining systems of patriarchy and capital endorsed by radical feminists, neo-marxists, dual systems theorists and others.

The concept of self-sustaining social systems which shape and limit social action leaves little space for diversity and difference, a critique which has been growing in recent years with the development of post-modern and post structuralist theories of social life. Such theories have emphasized difference, fragmentation and variation, factors not well addressed by systems theory in which homogeneous class and gender identities prevail. The tendency of feminist theory to adopt a meta-narrative or universalising approach has been critiqued by those who seek a theory that is historically contextualised and sensitive to the diversities and differences between women (Flax 1993; Fraser 1989, 1994; Weedon, 1999).

The concept of universal oppression of women by men has been challenged as pertaining to the experience of white middle class women, failing to adequately address issues of race, age and class etc.

Similarly the exclusive focus on economic rationality found in theories of proletarianization has been found lacking in explaining the motivation and means by which UK general practitioners have retained control over their labour process and economic position.

Postmodernism has adopted many forms but is united by the assumption that there is no one 'Truth' but many competing truth claims, involving a shift away from 'grand theory' to a more localized and contextualized approach. Thus a postmodern feminism would be:

‘..Comparativist rather than universalist and attuned to changes and contrasts instead of covering laws [and] would replace unitary notions of woman and feminine gender identity with plural and complexly constructed conceptions of social identity’ (Fraser 1989: 34-5).

Much of this work builds upon Foucault’s genealogical method of analysing power which involves a relative concept of truth, a capillary form of power and a notion of the human subject as constituted rather than constitutive. Thus there is a plurality of immeasurable discourses that succeed each other historically. Each discourse has its own matrix of practices which provide the basis for distinguishing between right and wrong, creating a power/knowledge regime. Each regime develops forms of social control which typically licence some with the authority to speak whilst excluding others. Power does not operate from ‘the top down’ but develops gradually, locally and in a piecemeal fashion. Whilst avoiding essentialist accounts of the state and capitalist class as the primary wielders of power, this position has been the subject of much criticism.

The ‘Cartesian Subject’, active, conscious, autonomous and creative is denied in Foucault’s concept of the constituted human subject, being instead the product of discourses prevalent within a specific historical context. This is a contentious position with significant consequences for political action:

‘It is difficult to understand how agency can be formulated on this view. Given the enormous productive efficacy Foucault accords power/knowledge or the dominant discourse, there could be agency only if human beings were given the casual ability to create, affect and transform power/knowledge or discourses, but Foucault does not concede to us this capacity...if Foucault’s analysis of subjectivity is correct, a feminist emancipatory project is in trouble’ (Alcoff in McWhorter 1999:75).

Further as Bradley notes:

‘Foucault refuses to accept that power has a subject (instead it is carried by discourses) or that it operates to further the interests of particular individuals or groups (we are all equally implicated in power relations)’ (Bradley 1999:32).

Thus whilst structural approaches have constrained our understanding of diversity and confined us to dualistic interpretations of social life as the result of self-sustaining systems of capitalism or patriarchy, post-modernist and post-structuralist approaches struggle to explain patterns of social interaction which, although subject to change

and variation, retain a remarkable consistency over time with very real implications in terms of unequal access to social resources and power as Bradley observes:.

‘.....class and gender, along with other concepts such as ethnicity and age, are terms which we employ to make sense of the way in which members of societies differ from each other...But while many post-structuralist assert that these terms *alone* constitute the ‘other’ as different’, I argue that there are indeed ‘real’ differences ‘out there’ to which these terms (if crudely and inadequately) correspond. These differences are lived relationships involving different access to social resources and power’ (Bradley 1999:21).

9.4 Structure and Action Re-Visited

The changes occurring in the management and funding of general practitioner services during the 1990s demand a holistic analysis which can adequately account for the role of the state, capital and gender in shaping the balance of power and authority in organisations and the agency of individuals within them.

In offering a resourced based account of power, Bradley is able to connect micro and macro levels of analysis, thereby linking structure and action. Developing Giddens resource based model, Bradley defines power: ‘very broadly as the capacity to control patterns of social interaction’ (1999:33). Thus there are many forms of power including (but not restricted to) class power, racial power, state power and gendered power within which various power resources (Giddens) are deployed. Forms of power are referred to as ‘dynamics’ rather than ‘structures’, being fluid and changeable as opposed to static ‘self-sustaining systems’.

There are significant benefits in the model put forward by Bradley which provides conceptual space for considering a range of ‘lived relationships’, avoiding the tendency of much structuralist thought to reduce all patterns of social interaction to the inevitable constraints of self-sustaining systems of class (capitalism) and gender (assumed to be patriarchal). Expressed as ‘dynamics’ rather than ‘systems’, existing ‘patterns of interaction’ restrict the possibilities of individual agency but can also be influenced by it, offering: ‘an account of power which enables us to study the processes by which actions transform structures, just as structures limit actions’ (Bradley 1999:223).

Adopting this model, we can identify state, class and gender power as the patterns of social interaction shaping the experience of general practice in the 1990s. Within these dynamics, empirical work has suggested that the following power resources are evident:

Economic Power: the control of economic resources

Positional Power: power and authority gained by holding positions such as employer, manager, supervisor, head of household etc.

Technical power: the deployment of technical expertise and mechanical competence

Symbolic power: the ability to impose one's own definitions, meanings values and rules on a situation

Collective power: the facility to organise groups of people to pursue common goals

Personal power: utilisation of personal resources such as strength of character, knowledge, ability, etc.

(From Bradley 1999:34-36)

9.4.1 State Power

Analysis at policy level has indicated how the State employed positional and economic power to impose contractual changes to GPs terms and conditions. The power of the state as the holder of the public purse in a health system funded by state taxation gave economic control in spite of the class position of GPs as self-employed contractors. As Freidson has noted in critiques of the proletarianization thesis:

'Owning property or the means of production, whether it is a professional practice or a shop, is not important in and of itself in assuring control over one's economic fate and autonomy in one's work. But if one's goods or services are not in heavy demand, then one will be confronted by indifferent consumers and at best will live "a life of dignified starvation....Whether one is employed or self-employed is beside the point. Given a strong position in the market, one can be employed and "write one's own ticket" nonetheless' (1984:9).

The positional power of the state enabled the introduction of legislation to change the GP contract and introduce an internal market in health care, against the collective

wishes of the profession. At this level then, the State succeeded in challenging the substantial 'collective power' of professional bodies.

The State is also identified in this analysis as attempting to wield 'symbolic power' in seeking to re-define the longstanding patient-practitioner relationship by introducing the role of GP as strategic purchaser of health care to meet identified population needs, alternatively termed by Derber (1983) as 'ideological proletarianization'. Whilst take up of the fund-holding scheme was widespread, data from interviews with managers and clinicians would indicate that the success of this strategy in 're-defining' the goals and orientation of individual clinicians from practitioners to strategic purchasers of health care was somewhat limited.

Qualitative work identified only one partner with a 'progressive' approach to the management of the practice, seeking to address the health care needs of the practice population. Thus clinicians, in the main, appear to have resisted this incursion into the definition of their work, employing their own significant resources of symbolic and technical power to retain traditional definitions of their role.

In addition to employing 'symbolic' strategies to 'win the hearts and minds' of GPs to state priorities and goals, a number of more direct controls have been identified by commentators as incursions on the clinical freedom of practitioners. The introduction of prescribing budgets, clinical guidelines and medical audit are some of the initiatives identified as increasing GP accountability and quality control.

Again, this work has demonstrated the minimal impact of such initiatives on the way in which GPs daily work is organised, structured and rewarded. Thus clinical guidelines were found to be a means for GPs to increase surveillance and control over other members of the health care team, formally defining the boundaries of clinical and nursing work and imposing routinised procedures to the tasks of the latter. The introduction of guidelines served to reinforce existing demarcation between clinical work, nursing and professions allied to medicine whilst leaving the assessment of clinical work firmly within collegiate control.

Further, the development of the health care team, viewed in the proletarianization thesis as a means of increasing both the specialization of clinicians and their reliance on other workers, has been demonstrated in the current analysis to extend the authority of the GP over a wider range of disciplines, using technical power to define the boundaries of clinical and nurse practitioner work for example.

However attempts to introduce 'managerialism' into general practice were to have a more significant impact on the profile and fortunes of existing managers in general practice. The language of markets and emphasis on the management of significant budgets via the fund-holding initiative did serve to raise concerns regarding the strength of existing management skills in the practice, and whilst this did not appear to extend to the management of clinical work per se partners, spurred by the requirements to demonstrate certain levels of managerial competence to join the fund-holding scheme and increases in the 'management allowance' made available for the reimbursement of management salaries, sought to recruit new managers or further develop the skills of existing staff.

9.4.2 Gender Power

The language of markets, finance and contract management have been demonstrably linked in interviews with GPs and managers to masculine models of management, whereas female managers are associated with 'people' and 'communication' skills, a common finding in much work on gender and management (Marshall 1984, McDowell 1997).

Work undertaken at the macro level has demonstrated the entry of male managers into general practice following the reforms of the 1990s, whilst qualitative work revealed a discourse in which male managers were identified, and identified themselves as 'the new breed', 'the new way', 'the future'.

Thus male managers employed symbolic power resources to re-define the role of management in general practice, de-valuing the 'traditional' practice management role and in some cases using the language of domesticity to link females with an administrative function akin to household management, re-asserting 'masculine' values and modes of acting as the essence of 'management'.

Personal power was used by males to define the 'professional manager' as having a distinct career history, involving a set of abilities, experiences and skills which could not be developed from a career within general practice. Furthermore, a distinct set of 'personality traits' were assigned to the sexes by managers and GPs whereby men were detached, strategic thinkers in comparison with females intuitive and caring nature – an identity that was defined by male managers as belonging to 'the past' in terms of the current and future needs of general practice.

The currency of personal power was used to levy higher salaries for male managers, despite qualitative analysis which revealed that 'female managers were delivering comparable roles. Quantitative data confirmed consistent inequalities across the sector in the pay and rewards of male and female managers, further reinforced by cross-sector national analyses.

Female managers demonstrated a painful awareness of the strategies of incoming males and adopted a range of approaches to counter the re-definition of what being a manager in general practice involved. 'Dual closure' strategies involved an acceptance of the differing 'skill sets' of male and female managers, with the former being defined as inappropriate to the existing culture of general practice. Women sought to challenge the superior value and better 'fit' of incoming male skills with the culture of general practice, arguing that general practice was not 'just another business' but a 'caring' institution in which the 'emotional labour' (Hochschild 1983) they undertook was an important, if financially unrewarded, contribution. Thus women used symbolic and personal power resources to define general practice as 'different territory', in which 'feminine' modes and values were more appropriate.

In contrast other women pursued 'inclusionary strategies' in challenging male claims over 'strategic management' skills and identified themselves as performing an equivalent, if not superior role in which rewards were determined by established and persistent discrimination on the basis of sex. Whilst supporting recent trends to recognise the diversity of women's experience this work also points to commonalities in the membership of the category 'woman', with female managers recognising their common ascription as 'the old type manager' on the basis of being female.

9.4.3 Class Power

Central to an understanding of the position and authority of managers in general practice is the somewhat unconventional personification of capital as key 'shop-floor' workers. Thus partners are the owners, solely or in partnership with other professionals of the practice, yet are also responsible for the bulk of service provision.

Thus managers in primary care are not only confronted by the technical and symbolic power of clinicians to define and control their own labour process, but are also subject to positional power as employees of the partnership. This ultimately meant that partners had the right of veto over any management decisions, as a collective group, or more commonly as individual practitioners. Significant levels of frustration were communicated in interviews with managers who were commonly denied one of the central tenants of 'managerialism' the ultimate 'freedom of managers to manage' (Pollitt 1993:2).

The collective power of the profession has succeeded in maintaining independent contractor status in spite of repeated attempts on the part of health ministers to draw them into a salaried service. This sustained victory has served to bolster the technical and symbolic power of clinicians with positional power vis-à-vis employed management personnel, an additional resource not shared by consultants in the acute sector.

9.5 The Intersection of Gender, State and Class

Whilst analyses of state power have indicated a weakening of the collective power of the profession to resist the imposition of legislative and contractual change, the impact of attempts to wield symbolic power resources in the re-definition of the role and focus of GPs work have been demonstrated to be somewhat limited in practice.

Employing significant positional, technical and symbolic power resources, some GPs have rejected outright, attempts to inject managerialism into their modes of defining, organising and delivering their work, refusing the invitation to join the fundholding scheme and promoting fears of a 'two tier' health care system. Others have chosen to

take up the 'opportunity' offered, identifying a chance to influence the practice of colleagues in the acute sector and to upgrade both human and capital resources within the practice. There was evidence to suggest that some GPs were seeking to introduce more radical change in to the organisation and running of their practices, however such cases were very much in the minority and often met with significant resistance from the wider partnership. Interviews with clinicians and managers therefore suggested little change in the outlook of GPs and the organisation of their work with collegiate forms of occupational control and the practitioner, as opposed to practice led approach to health care, remaining dominant.

The language of markets and strategic purchasing of health care have, however, had a demonstrable impact on the occupation of practice management, such language being associated with masculine modes of management, with incoming males using symbolic and personal power resources to re-define the practice management role.

Placed, however, within the context of a company of equals, in which the positional, technical and symbolic resources of clinicians are predominant, this work has pointed to a conflict in the incoming goals and expectations of male managers which could yet lead to the success of female discourses which have emphasized their better fit with the culture of general practice, albeit based on an acceptance of the ultimate authority of GPs to control the goals, values, delivery and rewards for their work.

SUMMARY

This chapter has assessed and evaluated the contributions of existing theory to an understanding of the dynamics identified in general medical practice during the study period. Structural theories of a decline in professional power brought about by the state and/or capital have been found lacking in their ability to take account of the agency of doctors and managers in challenging re-definitions of their role and rewards.

Whilst the Foucauldian concept of power operating at the local level and carried by multiple, relative and competing 'discourses' helps us to understand the micro exchanges between occupational and managerialist appeals to authority in general practice, this approach has been found lacking in its failure to accept the agency of

individuals in the creation of discourses, and in explaining the persistent material inequalities they produce.

Bradleys' development of Giddens resource based model of power provides the 'best fit' with data emerging from this work, offering the ability to connect micro and macro levels of analysis, thereby linking structure and action. Rejecting the concept of static systems, patterns of interaction are explained as 'dynamics' which both constrain and are influenced by individual agency. Adopting this model, state, class and gender power are identified as the patterns of social interaction shaping the experience of general practice in the 1990s. This finding is considered alongside other key messages in the following chapter which summarises the conclusions of this work.

CONCLUSIONS

INTRODUCTION

This study set out to explore the validity of claims that the power and authority of 'professional' workers to define and control their own labour and that of others has been significantly challenged by changes in health care policy introduced by consecutive Conservative administrations between 1987 and 1995. The setting for the research was the under-studied organisational structure of general medical practice in England and Wales.

Analysts of health policy in this period (Ham 1997, Pollitt 1993, Clarke and Newman 1993) identify a significant shift in the approach of the State to 'professional' workers, with the introduction of a 'managerialist' approach to health care, in which resources are directed to 'strategic' health goals and practitioners are held more directly accountable for the allocation of resources and achievement of specified outcomes.

Adopting an inductive approach this study aimed to explore the resulting impact on the organisation and control of clinical work and subsequent implications for managers and clinicians working within general medical practice:

- Had state policy succeeded in challenging 'professional' autonomy and introducing a more strategic approach to the management of health care resources?
- How had managers and clinicians responded to the external policy context?
- What were the implications for the roles and rewards of managers in general practice?

The objectives of the study embraced both micro and macro levels of analysis in assessing the external dynamics of policy imperatives, establishing the profile of practice managers and their rewards across England and Wales and exploring the roles of managers and clinicians within individual practices.

10.1 Relationship with existing studies

The inductive nature of this study, founded on a constructionist epidemiology and pluralist methodology has sought to investigate the experience and relationships between managers, clinicians and the state. Whilst existing works have analysed the relationship between managers and ‘professional’ workers (e.g. Freidson 2001), professional workers and the state (Rivett 1998), or the gendering of the management role (e.g. Hall Taylor 1997, McDowell 1997) none have brought the above together in analysing change within a specific organisational context.

Attempting to achieve a rounded analysis has resulted in a challenging study, which has drawn on a range of disciplines and bodies of literature. Areas of literature drawn upon in this thesis have included the study of professions and expert labour, policy analyses, management, gender and organisational studies.

Contributions from the study of professions and expert labour have demonstrated the ways in which professional workers have established a dominant position within the labour market which enables significant control over their own labour process and that of other occupational groups. Analyses of policy change have offered theories of the motivation and intent of policy makers in their challenge of these professional powers. Contributions from the fields of gender and organisational studies have shown the ‘gendering’ of occupations and brought the identity of the worker to the fore in analysing the ways in which occupations become defined and controlled.

Whilst the spread of analysis has, in some instances limited depth of study in any single area, the main benefit of the approach is the opportunity to avoid the ‘blind spots’ of individual disciplines e.g.:

- Policy analyses have been shown to over-state the impact of policy change on practice due to a focus on bargaining between the state and collective occupational bodies and subsequent neglect of relations at micro level where clinicians can resist and circumvent policy directives

- Writers such as Freidson bring significant insight into the management of expert labour yet fail to identify how strategies of occupational closure are also gendered in their impact
- Neo-Marxist analyses of the proletarianization of expert labour whilst of relevance in understanding aspects of UK health policy and its links with the management of a failing American economy (Clarke et al 1993), are undermined by their singular focus on structural relations between capital and worker.

10.2 Sited Analysis

That this study chose to focus on the setting of general medical practice rather than acute medical care is of significant importance in understanding the analysis presented and its wider application within the study of work and organisations. General medical practice presents a fundamentally different study environment to the large-scale bureaucracy commonly studied in research of this type. As sole trader or professional partnership, the UK general medical practice is comprised of self-employed practitioners, contracted to the state to deliver a range of agreed services. The manager operating within this environment is subject not only to clinicians control over their own labour process, but also the structural relationship of employment in which the manager is accountable to clinicians as partners in, and owners of, the business. The impact of this structure on the management of health care resources is vast, with primary care accounting for 75% of the total NHS budget in 2004.

The unique contribution of this study is therefore identified as its pluralist approach to understanding relationships between the state, occupations and genders in an atypical and under-studied organisational structure that makes a major contribution to the delivery of the National Health Service.

10.3 The concept of profession

The notions of 'professional work' and 'professions' are core to this debate and the thesis has drawn on historical analyses of the development of medical work and sociological explanations of the control of expert labour to develop an understanding

of general practice during the early 1990s. In particular this work has drawn on concepts of occupational closure, distinctions between hierarchical and technical forms of authority and resulting organisational forms such as the 'company of equals'.

The interpretation of 'profession' as a form of occupational control has been confirmed in this research, building on the work of Weber (1947) Freidson (1970) and Crompton (1990), amongst others. Thus appeals to 'professional' values, training standards and entry controls, ethics and oaths of practice are means by which occupational groups achieve occupational closure and the right of independent control over their own labour process and that of others.

The works of Weber are identified as making a considerable contribution to the study of expert labour, including the development of concepts of collegiality, occupational closure and status group. Webers' analyses of the development of legal systems demonstrated the power of lawyers' guilds in England to resist 'the rational codification of law' as a result of their occupational monopoly and influence in political life.

Parsons critique of Webers' more well known analysis of authority in bureaucratic organisations was to draw a critical distinction between authority on the basis of 'office' and authority on the basis of 'expertise', the two forms of authority being 'conflated' in Webers' formulation of the authority of office where positions in a hierarchy are determined by possession of technical expertise. Parsons identified alternative organisational forms in which 'technical experts' operated as 'companies of equals' in which membership was determined on the basis of credentialed knowledge and decision-making was via consensus, being inimical to the control of non-expert authority based on hierarchal position (Parsons 1957).

Freidson was to take up these concepts in a more critical analysis of the 'company of equals'. Freidson maintained the distinction between technical and positional authority, in his development of the concepts of organisational control via the 'occupational' and 'administrative' principle: the source of authority in the latter being the manager or administrator and in the former the professional or expert worker. In

an organisation controlled by the 'occupational principle', the organisation's central task, around which all other supporting activities are organised, is performed and controlled by professionals and management is 'stripped ofthe legitimate right to exercise imperative coordination' (1973:24).

The primary research undertaken as part of this thesis has provided strong corroboration of the concepts of a 'company of equals' and control via an 'occupational principle' within general medical practice: structures owned and controlled by clinicians who are also responsible for service delivery.

10.4 A Discourse of Managerialism

The link between the state and 'professional' occupational groups identified by Weber and later writers (Rivett 1998, Elston 1991, Hanlon 1999) has also been identified as a major factor in this thesis, intrinsically linked to the formation of professions (including legislation to enforce monopolistic rights to practice) and ongoing maintenance of their position. It is at the level of collective bargaining between professional bodies and the state where the most significant shift in power relations has been identified.

Analysis at the level of policy content has supported theories of a 'new managerialism' in public services, linked with the 'New Right' or 'Neo-liberal' ideology of the primacy of free markets.

Defined by Pollitt as:

'...a set of beliefs and practices, at the core of which burns the seldom-tested assumption that better management will prove an effective solvent for a wide range of economic and social ills' (1993:1);

managerialism is evident throughout policy initiatives in this period including the introduction of an internal market in health care, a shift from bureaucratic to contractual relationships between health care commissioners and providers, direct accountability for capped budgets in primary care, a requirement to plan health care

delivery on the basis of population need and a shift from per-capita to performance related payments, amongst other factors.

It has been argued therefore that the agent of change in the UK is the State; and whilst it is accepted that private sector practices and interests influenced state policy, it was not reducible to them (Clarke 1993, Pollitt 1993). Theories of declining professional power resulting from a progressive process of proletarianization in the interests of capital are therefore not supported by this thesis. With a focus on the transition of clinicians from self-employment to salaried practice in large-scale bureaucracies in the United States, the relevance of theories of proletarianization have been questioned in regard to the structure of UK primary health care, in which the vast majority of GPs retain self-employed status as sole practitioners or in partnership with other clinicians.

10.5 The Impact of Managerialism Within a Company of Equals

To understand the dynamics at work within general practice during the period 1987 to 1995 we must bring together macro and micro analyses and site them within an understanding of the distinct organisational culture and structure of 'professional' partnership, or 'company of equals' identified by Parsons and Freidson (1970).

The thesis has drawn on recent developments in organisational studies which have seen a shift in the understanding of 'organisational culture' as an entity which management can 'create' and manipulate (Peter and Waterman 1982) to an understanding of systems, practices and cultures as being the sum of past human agency, 'stored' within organisations (Halford et al 1997:15). The existing structure of general practice has been built and defended by the collective agency of an occupational group dating roughly from the nineteenth century. The result is an organisational culture saturated in the past agency of a 'professional project' which sought to define and claim an area of work as unique and subject only to the control of those sufficiently qualified to understand and implement it (Witz 1990). 'Professional' values and the primacy of the individual patient-doctor relationship are enshrined in this culture and provide the basis for the common assertion that general practice is 'not like a business'.

Drawing on this established position, general practitioners have demonstrated significant resilience to the not inconsiderable resources of the state to re-define their purpose and increase control over the labour process. Whilst powers have been challenged at the collective level, data at the micro level points to a continuation of professional freedoms to practice as independent clinicians within a 'company of equals' in which management supports, but does not direct, the provision of health care.

Whilst it can be argued, for example, that the political thrust of the fundholding initiative was to increase accountability and encourage a more strategic approach to resource management as part of an assault on professional autonomy (Klein 1995), depth interviews would suggest limited impact on the outlook or behaviours of clinicians. Interviews found little evidence to suggest an 'internalisation' of management values at the level of practice, showing no evidence of the 'ideological proletarianization' of the profession (Derber 1983).

A corporate approach to service delivery in which partners worked to common operational and strategic aims, objectives and systems was far removed from the reality of general practice identified in this research, demonstrating the continued strength of political and technical autonomy.

Policy changes were to destabilize the occupation of practice management however, creating 'gender struggles' in the re-negotiation of what it is to be a manager in general practice (Walby 1986). Large scale survey work has revealed a change in the profile and rewards of managers entering general practice during the early 1990s. The entrance of male managers and managers of both genders with a private sector background was changing the profile of this occupational group, previously dominated by women progressing mostly, though not exclusively, from within the ranks of general practice.

Chapter four drew on available labour market data to explore women's participation and rewards in the labour market, and in management functions in particular. The 'sex typing' or gendering of work roles such that they are ascribed to one sex or another and the segregation of men and women in different types of jobs are now well

documented by empirical study (Hakim 1979, Cockburn 1983, Bradley 1989, Adkins 1995). Labour market data demonstrates that women's participation in management roles is increasing but female managers are typically concentrated in functions and sectors with lower pay and rewards.

Interviews with doctors and managers revealed that the introduction of an internal market in health care and the drive towards more strategic allocation of health care resources brought new challenges and raised doctors' concerns regarding the suitability of existing management arrangements. Policy developments thus increased the profile of management in general practice and created a drive for the recruitment of 'proper managers'.

Within the paternalistic culture of general practice there were strong 'embedded' (Halford et al 1997) perceptions of a 'traditional' feminised practice management role of 'caring housekeeper' who:

'took on all the domestic chores, while hubby got on with the real (clinical) work and brought home the bacon.' (Huntingdon 1992:19).

Analyses that have explored the gendering of the management function (McDowell 1997, Green et al 1996) have shown the strength of associations with men, masculinity and management: 'think manager, think male' (Schein 1976). The language of markets, targets and strategic purchasing of health care services was seen to equate with the 'masculine' styles of 'professional' managers to be found in the private sector, evidenced in the views of clinicians and managers in depth interviews undertaken in this study.

The search for a 'real manager' was seen as synonymous with the search for a male manager in many of the practices surveyed. Male managers were defined and defined themselves as the 'new breed'. In this discourse women are characterised as the 'old style practice manager' unable or unlikely to keep up with the new demands on primary care.

Whilst it is noted that the concept of competing discourses lends itself to a Foucauldian analysis, in which a plurality of immeasurable discourses succeed each other historically, the constituted status of the human subject in Foucault's analysis is not borne out by the agency of managers to identify and create competing discourses as clearly evidenced in this work.

Drawing instead on Neo-Weberian analyses, the work of Witz has been used to demonstrate how gendered strategies of occupational closure developed. In recognising the threat from incoming male managers, women can be seen to have adopted two strategies: 'inclusionary' strategies where women defend their right to be valued on the same terms as men, seeking formal credentials for their experience and emphasising an equal skills set, and 'dual closure' strategies where female managers sought to under-mine the 'new management' discourse by claiming greater affinity with the existing culture in general practice as a 'caring organisation', emphasising their 'emotional labour' and 'people skills'.

Analysis of the actual roles of managers demonstrated that the 'new breed' was most likely to focus on the financial side of the practice and the management of the fund. Managers identified as genuinely operating at a 'strategic' level, involved in determining the direction and development of the practice, were few in number and as likely to be female managers promoted from within the practice as male managers recruited from public or private sector management.

How do we explain the complex interplay of factors that shaped the labour process and rewards within general practice?

10.6 A multi-dimensional account of social life

This research has demonstrated that the experience of work within general medical practice is multi-faceted, shaped by a number of differing sites of power including state, class and gender power. Structural analyses of power have constrained our understanding of diversity and confined us to dualistic interpretations of social life as the result of self-sustaining systems of capitalism or patriarchy, whilst post-modernist and post-structuralist approaches struggle to explain patterns of social interaction

which, although subject to change and variation, retain a remarkable consistency over time.

Social life is complex, multi-layered and dynamic and requires a theory of power that can accommodate its diversity. Chapter nine outlined Bradley's resourced based account of power and demonstrated its capacity to enhance our understanding of general practice organisations and their relationship with the state.

Defining power 'very broadly as the capacity to control patterns of social interaction' (1999:33) Bradley is able to offer a resource – based model of power which can connect macro and micro worlds and capture the complexity of power relations evidenced by this study.

Expressed as 'dynamics' rather than 'systems', 'patterns of interaction' develop over time and restrict the possibilities of individual agency but can also be influenced by it, offering: 'an account of power which enables us to study the processes by which actions transform structures, just as structures limit actions' (Bradley 1999:223).

Bradleys' resource-based model of power frees us from the constraints of binary concepts of the power of capital over the worker and the domination of men over women (patriarchy). In taking a resource-based approach to understanding the mobilisation of power in everyday practice, we are able to better understand its multi-faceted nature and make connections between macro and micro levels of analysis.

The identification of the state as an independent form of power frees us from the shackles of structural analysis where the state must be acting either in the interests of capital or men: in this analysis the state, whilst influenced by capital, is identified as acting in its own interests to retain office whilst rationing health care and targeting health spend.

Further the concept of multiple resources within sites of power enables us to discern how power can be effective in some forms and at some levels, whilst ineffective in others: thus the positional and economic power of the state as holder of the purse strings in a state managed health service, enabled the administration, at the collective

level, to force through unpopular health care reform in the face of the established power of a professional occupation to lobby and control the health care agenda, as evidenced in chapter three.

However the States' attempts to use symbolic power resources to re-define practitioners own sense of the purpose and goals of their work in everyday practice, were unsuccessful, often leading to a 'status quo' in which GPs continued to operate as independent clinicians with scant regard for the strategic implications of their clinical decisions, this being powerfully demonstrated in chapter seven. Thus whilst analysis of policy intent would suggest a significant challenge of professional freedoms, analysis at the micro level demonstrates successful resistance and indeed, enhanced authority for clinicians over a widening primary health care domain.

The power of general practitioners to resist the intent of policy change and attempts to control their labour process resulted in part from their class position as self-employed contractors to the state: in this structural arrangement managers did not have positional power resources to enforce decisions in their status as employees of the partnership. This position itself was the result of a successful professional project that achieved monopoly over a body of knowledge and related services thereby enabling the profession to dictate their terms of engagement with a state managed health service.

Established patterns of gender power have been revealed by quantitative survey work which demonstrated consistent inequality in the rewards of female practice managers, corroborated by cross-sector national analyses of the labour market. This was further supported by research at the micro level in which the incoming managerialist discourse is clearly identified as having a masculine identity, literally embodied by the entrance of male managers attracted by the increased rewards offered by the fundholding scheme.

Chapter eight has illustrated the agency of women in resisting this definition and utilising their own personal and symbolic power resources to place incoming males as the 'intruders' with values that are incongruous to primary care settings. Thus women have been both constrained by existing gender power which has defined management

as male territory, and have actively engaged in contesting such power by, amongst other strategies, an appeal to the established authority of professionals to define their work as 'different' and inimical to control by the authority of office.

Managers are identified as holding the weakest hand within the 'company of equals' formed by professional partnerships. The agency of general practitioners is again brought to the fore in their resistance to the authority of the new managers they had appointed: a conflict which saw the successful utilisation of technical and positional authority on the part of clinicians to limit and marginalize the input of managers to decision making and resource allocation. This work would suggest, that the success of the 'new breed' discourse will ultimately be determined by the outlook of partners, who maintain strong control over their labour process.

This work therefore calls for a multi-dimensional account of social life which can explain the complex interaction of differing sites of power, within which a wide range of power resources are deployed to achieve advantage. Whilst state, class and gender power have emerged as most significant in this analysis, it is recognised that others co-exist and emerge as predominant in differing empirical contexts e.g. race and age.

It is argued here that rather than being carried by self-sustaining systems, constraints on social action are created by the existing history of past agency, 'embedded' in social institutions and practices including workplaces, education and legislative systems etc. that both shape, and are shaped by the agency of individuals. This builds both on Bradley's concept of 'patterns of interaction' and Halford et al's concept of organisations as 'devices by which past forms of agency are stored' (Halford et al 1997:18).

The research findings therefore suggest that we need to embrace a multi-dimensional account of social life based on a concept of human agency that is both shaped by and formative of institutions and social practices.

10.7 Future Research

This work stands as a baseline measure of the early impact of managerialism on general medical practice, undertaken in the period 1994 to 1995 and following the introduction of the new contract and GP fund-holding. Policy has moved on considerably since the primary research conducted for this thesis, and much change has occurred in the position and organisation of primary care.

Key developments include the Primary Care Act of 1997 (D.O.H 1997), which prepared the way for the abolition of GP fund-holding in 1999, and the introduction of Primary Care Groups (PCGs). A subcommittee of the local health authority, PCG boards were comprised of clinicians, health authority and local government authority representatives and lay people. PCGs had three key functions: to contribute to improving the health of their local community focusing particularly on sections of the population with the greatest need; to develop primary care and community services based on identified health needs; and to advise the health authority on, or commission directly, secondary care services (Cheater, 2001).

From April 2004 all PCGs became Primary Care Trusts (PCTs) freestanding NHS primary care organizations accountable to local Strategic Health Authorities. There are 303 PCTs in England, each charged with planning, securing and improving primary and community health services in their local area (RCGP 2004¹). The PCT board is comprised of a majority of lay members, who work closely with the PCT executive representing general practitioners, nurses and other community staff. PCTs have the same functions as PCGs but in addition they may provide services, run hospitals and community health services, and employ staff. Together PCTs controlled 75% of all NHS expenditure in 2004.

From 2003 selected PCTs have the opportunity to become new single multi-purpose legal bodies to commission and be responsible for all local health and social care, known as Care Trusts (D.O.H 2000). Care Trusts are able to commission and deliver primary and community health care as well as social care for older people and other client groups. Social services are delivered under delegated authority from local councils. This significantly extends the scope and remit of primary care far beyond its

beginnings at the inception of the NHS and the subsequent reforms of the 1970s and 1990s.

Fundamental changes have also taken place in relation to the structural relationship between individual general practitioners and the state. The 1990 General Medical Services Contract took the form of statutory arrangements entered into by individual GPs as independent contractors. In the new General Medical Services Contract *practices*, not individual GPs, have entered into contracts with their local Primary Care Trust/Group *thus changing the legal basis of the contract* (DO.H 20042). A global sum is allocated to the practice enabling the flexibility to develop services according to need, including the option of extending partnership status to members of the wider primary health care team:

It is a UK-wide contract with the protection of UK negotiation. The standard contract is signed by all the partners of the practice, at least one of whom must be a GP. Practices are now allowed to include in their partnership staff from the wider primary healthcare team such as practice managers, nurses, allied health professionals, and pharmacists (RCGP 20042:2).

As in previous reforms moves to increase freedom at the local level have been coupled with strong central controls in the form of targets and performance indicators. A modernization board and agency have been introduced to 'support NHS clinicians and managers in their efforts to improve their services' (D.O.H 2001)

These developments raise a number of important questions for future investigation:

- Will the radical break in the basis of the contract for General Medical Services prove to be a catalyst for developing a more corporate approach to health care?
- Will the legal freedom to appoint Managers and other practice staff as partners within the practice be taken up and how will this effect the 'company of equals' identified in this and other work?
- PCG and PCTs have introduced a shift away from the practice (or singular practitioners) as the holders of purse strings as found in the fund-holding scheme, to a committee structure with significant lay representation. What are the opportunities for managers in this setting and how will it affect the

political and technical autonomy of clinicians working within and outside of committee structures?

- With the introduction of Care Trusts and mergers of practices and PCTs there is a trend towards organisations of increasing size. Increased opportunities for salaried GP status are also being created: could this yet be a move towards the proletarianization of general practitioners?
- Finally how will all of the above impact on the gendering of the management function in primary care? Have female managers succeeded in breaking down the image of the 'caring housekeeper' and has the 'new breed' of male manager resisted or succumbed to control via the 'occupational principle'?

Whilst recent policy developments would suggest a significant movement in the direction of a 'strategically managed' health care service this work has demonstrated the dangers of imputing change from an appraisal of policy intent: to establish the answers to these fascinating questions further research is required.

In conclusion this thesis has provided a 'line in the sand' against which the impact of the above developments can be measured. Had state policy, introduced in the period 1987 to 1995 succeeded in challenging 'professional' autonomy and introducing a more strategic approach to the management of health care resources? The answer is yes and no: at the collective level the state achieved a victory in introducing a managerialist agenda to primary care; the delivery of this agenda was weakened by the symbolic, technical and positional resources utilised by professionals in the definition, management and control of their work on a day to day basis.

What were the implications for the roles and rewards of managers in general practice? New opportunities were created by the catalyst of GP fundholding including higher salaries and rewards and the promise of influence over the delivery of healthcare services. Patterns of social interaction which defined management as masculine and medical labour as inimical to the 'authority of office' constrained these opportunities for both men and women: incoming managers with private sector backgrounds faced the challenge of control via an occupational principle, female managers encountered,

and resisted, the double challenge of professional authority and male embodiment of the management role.

The unique contribution of this study is identified as its pluralist approach to understanding relationships between the state, occupations and genders in an atypical and under-studied organisational structure which makes a major and ever increasing contribution to the delivery of a national health service.

It is strongly recommended that this work be re-visited in the near future to measure the impact of the last decade of policy change on managers and clinicians in primary care. It is further recommended that future research programmes maintain pluralism in methodology, flexibility of outlook and openness of mind that we might capture the complexity of social life and all its voices.

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APPENDIX ONE: SURVEY AND INTERVIEW DOCUMENTS

Partner Interview Guide

Area	Prompts
Partner involvement in management	<ul style="list-style-type: none">• Do the partners have particular management responsibilities?• How did this arrangement come about?• How does this work in practice?
Perceptions of existing manager's role	<ul style="list-style-type: none">• Could you summarise the main responsibilities of the current manager• Have these changed in the last five years? How?
Ideal managers role	<ul style="list-style-type: none">• Can you summarise what you think the ideal practice manager role would be?• What skills would this require?• What type of experience and background would you expect such a person to have?• How does your present manager compare to your ideal of a manager in general practice?
Gender	<ul style="list-style-type: none">• Are there any differences in male and female managers approach to the role?
Managers and clinical work	<ul style="list-style-type: none">• Do you think there are any areas where management and clinical issues overlap?• Do you involve the present manager in these areas? How?

Practice Manager Interview Guide

Area	Prompts
Description of current and ideal role	<ul style="list-style-type: none"> • If you were writing your own job description as it is now what duties would this include? • Ideally, what should the role include/involve? And how does this compare with your current role? • Are there any areas where you would like to extend/change your input?
Managing clinical work	<ul style="list-style-type: none"> • Are you involved in organising the partners work in any way? (PACT data, health targets, audit, assessing population health needs etc.) • Do partners work to common systems and procedures?
Gender	<ul style="list-style-type: none"> • Are there any differences in male and female managers approach to the role?
Skills	<ul style="list-style-type: none"> • What skills do you feel you bring to this job? • Are there any skills you feel you have that are not put to best use? • Do you think the partners recognise the skills you contribute? (salary and rewards, involvement in decisions) • How have these skills been developed? (explore work history, management training)
External contact	<p>Are there any people/agencies that you consult for advice and support?</p> <p>Who would you say are your peers?</p>
Future	<p>How do you see your future?</p> <p>How would you like to see your role develop?</p> <p>Will anything impeded or prevent your further development?</p>
Salary	Check salary band

UNIVERSITY of  at NEWCASTLE

Department of Applied Social Science

Human Resource Management in General Practice

**Self completion questionnaire
for Practice Managers**

January 1994

Department of Applied Social Science Acting Head: John Newton

Northumberland Building
Newcastle upon Tyne NE1 8ST
Telephone (091) 227 4637
Fax (091) 227 4558

Direct Telephone Line

Dear Practice Manager,

**Human Resource Management in General Practice
A nationwide postal survey**

The attached questionnaire is part of the first phase of fieldwork in a three year investigation into human resource management in general practice. The project is funded by the University of Northumbria at Newcastle and is supported by the Royal College of general Practitioners (RCGP) and the association of Health Centre and Practice Administrators (AHCPA).

As you will be aware, the thrust of change in the health services in the 1990's is towards primary care. Efficient and equitable human resource management systems will assist the primary care sector in meeting the additional pressure generated by such change.

It is hoped that the study will help practices through the achievement of the following outcomes:

1. A representative picture of how human resource management is currently organised in British general practice.
2. A basis for policy formulation by health administrators and general practices.
3. A set of tools for conducting future training and human resource audits in general practice.

Your participation in the survey would be greatly valued. All information provided will be treated as strictly private and confidential. Analysis and publication will not identify individual practices.

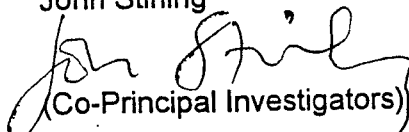
We look forward to receiving your completed questionnaire and would like to take this opportunity to thank you for your time and co-operation.

Yours faithfully

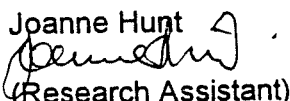
John Newton



John Stirling


(Co-Principal Investigators)

Joanne Hunt


(Research Assistant)

Completing the Questionnaire

Please read the following guidelines before completing the questionnaire:

Where the question is followed by empty boxes please write your answer in the boxes provided.

In all other cases the question will offer a number of coded responses. Where there is no further instruction please circle one response only.

Further instructions may ask you to:

Circle one response for each case or circumstance given;

Circle all appropriate codes for the case/circumstance given.

The questionnaire should take approximately 25 minutes to complete

Human Resource Management In General Practice.

Section One

The following questions ask for details about your age, sex, current post and professional background.

1. Are you

Male 1

Female 2

2. What is your age?

Under 25 1

25 to 39 2

40 to 59 3

60+ 4

3. What is the title of your current post?

Practice Manager 1

Practice Administrator 2

Fund Holding Manager 3

Other (please specify) _____

4. How many hours a week, on average, do you work?

Less than 20 1

20 to 29 2

30 to 39 3

40 to 49 4

50+ 5

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1	2	3
4	5	6

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5. Please indicate the band within which your current salary falls,
(Figures shown in £s per annum)

Less than 8,000	1
8,000 to 9,999	2
10,000 to 15,999	3
16,000 to 20,999	4
21,000 to 25,999	5
26,000 or more	6

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6. How long have you been employed in your current post?

Less than 1 year	1
1 to 2 years	2
3 to 5 years	3
6 to 10 years	4
11 years or more	5

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7. If you have worked before your current job, was your immediate past post in:

This practice	1
Another practice	2
Public sector management	3
Private sector management	4
Not applicable	5

Other (please specify) _____

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8a. Have you ever received any formal training in human resource management or personnel management?

Yes 1 Please go to question 8b.

No 2 Please go to question 9.

8b. To what level?

Please circle all relevant responses

Post graduate 1

Under graduate 2

Diploma/Cert 3

BTEC 4

Short courses 5

Other (please specify) _____

9. Are you a member of any of the following professional bodies?

Please circle all relevant responses

Association of Medical Secretaries 1
and Practice Administration Staff (AMSPAR)

Association of Health Centre 2
and Practice Administrators (AHCPA)

Guild of Medical Secretaries 3

Institute of Personnel Management (IPM) 4

Institute of Health Service Management (IHSM) 5

None of the above 6

Other (please specify) _____

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Section Two

The following questions ask for details about the practice and the practice partners.

10. What is your practice list size?

- | | |
|----------------------|---|
| Under 3,000 patients | 1 |
| 3,000 to 4,999 | 2 |
| 5,000 to 9,999 | 3 |
| 10,000 to 14,999 | 4 |
| 15,000 + | 5 |

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11a. Is your practice fund holding or in the process of applying for fundholding status?

Yes 1 Please go to question 11b.

No 2 Please go to question 12.

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11b. Please specify when the practice achieved, or expects to achieve, fundholding status.

- | | |
|------------------------|---|
| In process of applying | 1 |
| 1991 (Wave 1) | 2 |
| 1992 (Wave 2) | 3 |
| 1993 (Wave 3) | 4 |
| 1994 (Wave 4) | 5 |

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12a. How many fully trained general practitioners are contracted by the FHSA to work:

26 hours or more

Up to 19 hours

Up to 13 hours

Other (Please specify) _____

12b. How many GP trainees are there at the practice?

13. Please record the age of each partner using the age bands shown below:

Please circle the appropriate response for each case.

		25 to 39	40 to 59	60+
Partner	1	1	2	3
	2	1	2	3
	3	1	2	3
	4	1	2	3
	5	1	2	3
	6	1	2	3
	7	1	2	3
	8	1	2	3

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14a. Does one of the partners take special responsibility for staffing/personnel matters?

Yes 1 Please go to question 14b

No 2 Please go to question 15

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14b. Does this partner have any formal training in human resource management or personnel management?

Yes 1 Please go to question 14c

No 2 Please go to question 15

Don't know 3 Please go to question 15

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14c. To what level?

Please circle all relevant responses

Post graduate 1

Under graduate 2

Diploma/Cert 3

BTEC 4

Short courses 5

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Other (please specify) _____

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15. How long has the practice had a Practice Manager (or equivalent post)?

Less than 1 year 1

1 to 2 years 2

3 to 5 years 3

6 to 10 years 4

11 years or more 5

No practice manager or
equivalent post 6

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16a. Please state the **total** number of staff working in or from the practice, including nurses, receptionists, cleaners etc. but excluding partners:

16b. How many of these staff are receptionists/clerks/secretaries?

16c. How many staff are **attached** to the practice?

16d. Of the attached staff, how many are:

Part time

Full time

Work less than 10 hours per week for the practice

Work on temporary contracts (less than 1 year)

16e. How many staff are **employed** by the practice?

16f. Of the employed staff how many are:

Part time

Full time

Work on temporary contracts (less than 1 year)

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Section Three

The following questions ask for details about how the practice deals with various staffing matters. The questions aim at finding out the different ways in which these matters are dealt with in general practice.

17. Who would normally have the authority to make decisions on the following hypothetical issues?

Please circle all those personnel who would have the authority to make the decision (this could be more than one of the following categories in some cases).

Key:

One partner with a special responsibility for staffing matters	1
Partners in general	2
Practice Manager	3
Head of section/department e.g. Senior Receptionist.	4

	1 Partner	Partners in general	Practice Manager	Head of section/ department
Make the final decision on the candidate selected for a receptionist post	1	2	3	4
Decide to introduce a training course for practice staff	1	2	3	4
Decide appropriate action when a non-clinical member of staff has allegedly been rude to a patient	1	2	3	4
Decide to promote a receptionist to senior receptionist post	1	2	3	4
Decide appropriate action when a grievance is raised by a cleaner	1	2	3	4

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Question 17 continued.**Key:**

One partner with a special responsibility for staffing matters	1
Partners in general	2
Practice Manager	3
Head of section/department e.g. Senior Receptionist.	4

	1 Partner	Partners in general	Practice Manager	Head of section/ department
Decide to introduce new system for recording minor accidents in the practice	1	2	3	4
Decide appropriate action when a practice nurse has allegedly been rude to a patient	1	2	3	4
Make the final decision on extending surgery hours	1	2	3	4
Decide to dismiss a secretary for stealing from petty cash box	1	2	3	4
Decide appropriate action when a candidate for a job alleges to have been the victim of sexual or racial discrimination	1	2	3	4
Make the final assessment of the performance of a member of non-clinical staff in an appraisal exercise	1	2	3	4
Make the final assessment of the performance of a district nurse in an appraisal exercise	1	2	3	4

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18. How precisely do formal rules, policies and/or procedures specify the way that the following matters are handled in your practice?

Please circle the appropriate response for each matter.

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	Very precisely	To a moderate extent	Not at all	Not Applicable
Grievances	1	2	3	4
Recruitment	1	2	3	4
Discipline	1	2	3	4
Redundancy	1	2	3	4
Trade Union recognition	1	2	3	4
Staff Development	1	2	3	4
Maternity leave	1	2	3	4
Promotion	1	2	3	4
Staff appraisal	1	2	3	4
Health and safety	1	2	3	4
Equal opportunities	1	2	3	4

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19. Does the practice have **written** policies concerning any of the following matters?

Please circle the appropriate response for each matter

	Yes	No	Under discussion	Not Applicable
Grievances	1	2	3	4
Recruitment	1	2	3	4
Discipline	1	2	3	4
Redundancy	1	2	3	4
Trade union recognition	1	2	3	4
Staff development	1	2	3	4
Maternity leave	1	2	3	4
Promotion	1	2	3	4
Staff Appraisal	1	2	3	4
Health and safety	1	2	3	4
Equal opportunities	1	2	3	4

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20. Do any of the following people in the practice have **written** statements which define their **everyday** duties and responsibilities?

Please circle the appropriate response for each case.

	Yes	No	Under Discussion	Not applicable
Assistant practice managers	1	2	3	4
Cleaners	1	2	3	4
Fund manager	1	2	3	4
Practice manager	1	2	3	4
Practice nurses	1	2	3	4
Receptionists	1	2	3	4
Secretaries/clerks	1	2	3	4
Senior receptionist	1	2	3	4

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21. How often does another member of staff in the practice do the work of the following people?

Please circle the appropriate response for each case.

	Frequently	Occasionally	Never	Not Applicable
Assistant practice managers	1	2	3	4
Cleaners	1	2	3	4
Fund manager	1	2	3	4
Practice manager	1	2	3	4
Receptionists	1	2	3	4
Senior receptionist	1	2	3	4
Secretaries/clerks	1	2	3	4

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22. How many different members of staff are routinely involved in performing the following tasks?

This question has two parts, please:

A. State the total number of staff involved in the task in the boxes provided.

B. Identify who performs these tasks by circling the appropriate codes.

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	Total no. of staff	Partner/s	Practice Manager	Clinical staff	Clerical staff	N /A
Administering statutory sick pay arrangements	<input type="text"/>	1	2	3	4	5
Maintenance and updating of personnel records	<input type="text"/>	1	2	3	4	5
Organisation of non-clinical staff training	<input type="text"/>	1	2	3	4	5
Organisation of non-clinical staff appraisal	<input type="text"/>	1	2	3	4	5
Ensuring that staff accidents in the practice are recorded	<input type="text"/>	1	2	3	4	5
Placing a recruitment advertisement for non-clinical staff	<input type="text"/>	1	2	3	4	5

23a. We would like to find out the influence of external agencies on the way staffing matters are dealt with in the practice. External agencies may include:

Family Health Service Authority (FHSA)
 District Health Authority/ Regional Health Authority (DHA/RHA)
 Advisory Conciliation and Arbitration Service (ACAS)
 Institute of Personnel Management (IPM)
 Trade Union Congress (TUC)
 Royal College of Nursing (RCN)
 Royal College of General Practitioners (RCGP)
 Association of Health Centre and Practice Administrators (AHCPA)
 Association of Medical Secretaries and Practice Administration Staff (AMSPAR)

Please consider the extent to which such agencies influence the following issues in connection with **non-clinical practice staff such as receptionists and secretaries.**

Please state the name of the influencing body/bodies where relevant.

	A great deal of influence	Quite a lot of influence	Influential to some extent	A little influence	No influence	Don't know	Name of body
Grievances	1	2	3	4	5	6	_____
Recruitment	1	2	3	4	5	6	_____
Discipline							
Redundancy	1	2	3	4	5	6	_____
Trade union recognition	1	2	3	4	5	6	_____
Staff development	1	2	3	4	5	6	_____
Maternity leave	1	2	3	4	5	6	_____
Promotion	1	2	3	4	5	6	_____
Staff Appraisal	1	2	3	4	5	6	_____
Health and safety	1	2	3	4	5	6	_____
Equal opportunities	1	2	3	4	5	6	_____

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23b. Please consider the extent to which such agencies influence the following issues in connection with **clinical practice staff such as practice nurses and district nurses**. This should not include the partners

Please state the name of the influencing body/bodies where relevant.

	A great deal of influence	Quite a lot of influence	Influential to some extent	A little influence	No influence	Don't know	Name of body
Grievances	1	2	3	4	5	6	_____
Recruitment Discipline	1	2	3	4	5	6	_____
Redundancy	1	2	3	4	5	6	_____
Trade union recognition	1	2	3	4	5	6	_____
Staff development	1	2	3	4	5	6	_____
Maternity leave	1	2	3	4	5	6	_____
Promotion	1	2	3	4	5	6	_____
Staff Appraisal	1	2	3	4	5	6	_____
Health and safety	1	2	3	4	5	6	_____
Equal opportunities	1	2	3	4	5	6	_____

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Thank you very much for your time and co-operation.

If the practice has written procedures and/or policies on any staffing matter, including job descriptions, we would be extremely grateful if you could include copies with the returned questionnaire.

We would welcome any comments you may wish to make on the content and design of the questionnaire:

This survey is the first phase of a three year investigation into HRM in general practice. The second stage involves making visits to practices and looking at the way HRM policies and procedures are carried out in greater detail. If you are selected for the second stage your participation would be greatly appreciated. Please indicate below if you would be interested in continuing your participation.

*I would/would not like to participate in the second stage of the project.

*I would/would not like to see a synopsis of the survey's findings.

* Delete as appropriate.

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APPENDIX TWO: RELATED PUBLICATIONS

Employment relations in small service organizations

The case of general practice

John Newton

*Division of Employment Studies, University of Northumbria,
Newcastle upon Tyne, UK and*

Jo Hunt

University of Durham, Durham, UK

Employment
relations in
small service
organizations

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Received October 1995
Revised March 1996

Introduction

The discipline of industrial relations has developed theories and concepts to understand the structure and processes of employment relations in the settings which have hitherto dominated the twentieth century world of work. Thus, industrial relations in large scale manufacturing organizations, largely staffed by male manual workers, have frequently, if not typically, been characterized by institutionalized antagonism between employers and employees and with terms and conditions being settled through formal and informal bargaining. Explanatory models have ranged from Marxist to pluralist (Gospel and Palmer, 1993). Although this formalized, collectivized and now legalized system of industrial relations is still the predominant mode of job regulation in many sectors of the economy the rapid growth of service industries and service employment (Naylor and Purdie, 1992) is creating different arrangements. Many of the firms and organizations in the service sector are small; women form the majority of their workforces (Department of Employment, 1992); and, according to a recent report: "trade unions (have) made little impact on these firms" (Curran *et al.*, 1993, p. v). Such features may require a revision of the theories and models used to describe and explain industrial relations in manufacturing industries.

Previous attempts to describe the character of employment relations in small non-unionized organizations have often been criticized for over generalizing (Curran, 1991). Early commentaries, for example, tended to concentrate on the nature of interpersonal relations between managers/owners and employees and smallness was seen as positively conducive to personal, informal and harmonious relations (Bolton Report, 1971). More recent research has shown this to be a "modern myth" (Rainnie, 1985) and has refined our understanding of the market position of small firms by the development of typologies of their dependency relationship with large firms (Rainnie, 1989). These relations have subsequently been shown to influence a range of management styles from "fraternalism" and "paternalism" to "autocracy" and "sweating" (Goss, 1991).

These analyses, however, are based on studies of small *firms*. There have been very few studies of employment relations in small non-profit making

organizations, or of service organizations within this category. This is unfortunate since it has been pointed out that the delivery of public sector services "sets up special problems for management and results in distinctive practices by managers" (Ackroyd *et al.*, 1989, p. 603). The problems referred to by these authors are mainly concerned with managers' "needs to mediate relationships between clients of a service and its funders" and the practices are related to the typical strategy of granting service deliverers considerable autonomy from direct managerial control. It would be surprising if these problems and practices did not frequently impinge on matters concerning managers' relationships with employees.

In order to explore the issue of managing employment relations in small non-profit making organizations we focus in this paper on general medical practice. This is an expanding sector of the NHS which currently employs approximately 100,000 people and accounts for 20 per cent of the total NHS budget (Department of Health, 1994). In our view it has been neglected in recent discussions of industrial relations in the health service. Seifert's (1992) review, for example, focuses on pay relativities between the different NHS occupational groupings and the bargaining arrangements for regulating pay and conditions. Where there is a sectoral focus, it is almost exclusively concentrated on hospitals.

General medical practice is a service delivered by an established professional group (general practitioners) in collaboration with teams of other professionals and mainly non-unionized female white collar staff. The first part of the paper briefly outlines the development of general practice and describes how it is currently organized and staffed. The second part focuses on the employment relationship in general practice and considers some of its distinctive features. The findings from a survey of staff management procedures in general practice will be used in the third part of the paper to discuss how the character of general practices as service organizations affects the patterning of their employment relations. Throughout the paper the term "employment relations" is used in preference to "industrial relations". This is meant to indicate agreement with Sisson's (1991) view that workers in the service sector are an "obvious case" for extending discussion beyond the traditional concerns of academic industrial relations. Contrary to Sissons, however, we feel that it does matter whether such studies are subsumed under the heading "industrial relations". If their focus is "the employment relationship and the way that is managed...regulated, or controlled" (p. 9) then the term employment relations seems more appropriate.

General practice: past, present and future

The National Health Insurance Act of 1911 introduced a panel system whereby general practitioners, usually working from their homes, provided free medical attention to insured working men (their wives and dependants were not generally covered and were left to fend for themselves). A more comprehensive service was not forthcoming until the National Health Service Act of 1946. This

provided all of the population free access to general practitioners (GPs) who were and still are, independent contractors with the NHS.

GPs were to be paid on a capitation basis but there were no provisions enabling doctors to employ any support staff or to buy/rent special purpose premises. General practice, therefore, remained as a cottage industry and GPs continued to feel isolated with few incentives to improve the quality of their services. Not surprisingly, from the mid-1950s there was a large drop in the number of medical graduates entering general practice (DHSS, 1969).

Faced with this problem the bodies representing general practitioners urged the government to improve the structure and status of general practice. Negotiations between the DHSS and the BMA's General Medical Services Committee resulted in the 1996 Family Doctors' Charter. This encouraged the establishment of group practices on a partnership basis by the payment of allowances for premises and support staff to those doctors who shared premises with at least two other principals. Simultaneously this provision also promised to end the professional isolation of single-handed practitioners and made arrangements for out-of-hours cover much easier. By way of an incentive to improve practice, additional payments were to be paid for cervical cytology, immunizations and maternity clinics (Jefferys and Sachs, 1983). In parallel with the Charter initiative the government proposed to enhance further the attractiveness of general practice by encouraging local authorities to build health centres in which GPs would be provided with up-to-date premises and with ancillary professionals such as health visitors and district nurses employed on an attachment basis.

As a result of these changes the structure of general practice changed dramatically. Table I shows that in 1972 19 per cent of general practitioners worked single handedly (the proportion in 1946 had been 80 per cent) and that the modal size of partnership was one of two or three partners. By 1982 the proportion of single handed GPs had dropped to 13 per cent and while the modal partnership size was still two or three, larger partnerships were increasing. These trends have continued so that today barely 10 per cent of GPs

Type of practitioners	1972		1982		1992	
	Number	(%)	Number	(%)	Number	(%)
Single handed	3,847	(19)	2,967	(13)	2,866	(11)
In partnership of:						
2/3 doctors	9,487	(48)	9,024	(40)	8,201	(31)
4/4 doctors	5,067	(26)	7,600	(33)	8,807	(34)
6+ doctors	1,374	(7)	3,195	(14)	6,194	(24)
All doctors	19,775		22,786		25,968	

Source: Department of Health, Health & Personal Social Services Statistics (1994)

Table I.
Size of general practice
partnerships 1972-92

work on their own and an increasing proportion of GPs work in partnerships of six or more doctors.

Alongside and pegged to, these changes came the employment or attachment of an increasing number of ancillary professional and administrative staff. Between 1984 and 1994, for example, the number of whole time equivalent practice staff directly employed increased from 25,994 to 51,833 (Department of Health, 1995). Up to 1990 a practice could employ two ancillary staff for every full-time GP and the Family Practitioner Committee (FPC) (as was) would reimburse the practice 70 per cent of those staff costs. The local health authority would also ensure that an appropriate number of health visitors and district nurses were attached to each practice. Since 1990 Family Health Service Authorities (FHSAs) (who replaced the FPCs) have had a cash limited staff budget and have more discretion regarding the categories of staff to be included as well as how much might be reimbursed. For practices this means that they can claim payment for a wider range of staff (including, say, physiotherapists and counsellors) and have more latitude in defining staff terms and conditions within the broad ranges set down in the NHS Review Body and Whitley Council recommendations.

Even greater discretion is extended to the fundholding practices established since April 1991. These practices are allocated a budget to cover the cost of hospital services, prescriptions, staff and premises. The number of fundholding practices is currently 2,200 (approximately one third of practices) covering 50 per cent of the population (Audit Commission, 1996) and is likely to rise now that the government have announced plans to make it easier for smaller practices to participate in the scheme (NHSME, 1994). Coupled with the general thrust to create a primary care-led NHS, GPs look set to become employers of a complex grouping of professional and administrative staff.

The employment relationship in general practice

Two recent textbooks have affirmed the centrality of the employment relationship in the study of industrial relations. For Blyton and Turnbull it is "the basis of the parties' own interactions and the relationship upon which all other aspects of employee relations develop" (Blyton and Turnbull, 1994, p. 5); and in the same vein Edwards introduces his textbook on industrial relations with the proposition that industrial relations "is about the ways in which the employment relationship is regulated" (Edwards, 1995, p. 5). Both texts proceed to map out a broadly similar territory from this core facet. The main tasks of the discipline are to define the distinctiveness of the employment relationship and to understand this as the product of both employer and employee strategies, played out within an environment defined by the social economic and political context of the workplace setting. The remainder of this section follows this agenda with respect to the employment relationship in general practice. In the next section employer (or managerial) strategies are considered by way of an examination of the organizational arrangements which they have established.

The socio-economic environment of general practice is addressed in the final section.

General practice partnerships, as we have seen, may employ ancillary staff such as nurses, managers, secretaries, clerks and receptionists. Up to 1990 the numbers of such staff were fixed according to the number of full-time equivalent practitioners. This is still the case today but now the staffing budgets of FHSAs are cash limited and practices have to make bids to employ additional staff or to regrade existing staff. In addition, the Health Authorities (or Commissions) attach other professional staff such as district nurses, midwives and health visitors to practices. These staff are for the most part employed by the commissioning authorities, though there are moves in some regions to change the arrangements so that these staff become directly employed by practices. Whether employed or attached, most of the ancillary staff have their terms and conditions of employment set by NHS Review Bodies or Whitley Council recommendations. As such the typical employment relationship in general practice is mediated by external organizations and arrangements.

A further distinctive, though not unique, feature of general practice is the high proportion of professionally qualified staff employed. The core tasks are performed by doctors, nurses, health visitors, dieticians and others; while increasing numbers of accountants are being recruited to the staff of fundholding practices. The significance of the professionalized character of primary health care teams lies in the different principle of control which is held to regulate their work. As Freidson (1973) suggests, professions are organized around "the occupational principle" which leads them to assert vigorously their autonomy and to be resistant to managerial or administrative/bureaucratic strategies of control. This implies that a professionalized labour force is one that is expected to exercise initiative and is motivated to do so. Consequently, the need for hierarchical control and supervision is sharply reduced. As Fox (1974, p. 34) puts it: "the nature of co-ordination among the occupants of (high discretion) work roles differs from that among occupants of low discretion roles. The need is more for problem solving relations than for standardized externally imposed co-ordination".

Fox's main point about people in professional (or high discretion) roles is that their loyalty and support is taken for granted. Employment relations in such a setting are less likely to take on a conflictual character since lateral and vertical trust relations (Fox, 1974, p. 35) are high and colleagues are assumed to be motivated towards the achievement of shared goals; which, in the context of general practice, might be: "the well being of the patient". This, of course, is an idealized representation. The rapidly changing nature of primary care and the increasing pressure on clinicians to be accountable for their "expenditure" is likely to make actual work settings more fragile. Practice managers and fund managers are emphasizing the budgetary implications of prescriptions and referrals; clinicians are putting pressure on nurses and ancillary staff to meet health targets on which a larger proportion of practice income now depends;

and patients are taking advantage of their modest empowerment by the Patients' Charter. Even the idealized pattern of trust relations, therefore, must be under threat from the changing structure of health care.

Finally, general practices – like many parts of the service sector – have a large proportion of women in their workforce (Department of Employment, 1992). Similarly, a large proportion of these women are employed or are attached on a part-time basis. Since workforce composition in terms of gender and employment status has been identified as one of the factors which might be expected to influence employment relations (Curran *et al.*, 1993) it is worth considering the implications of these particular, if not distinctive, features of general practice here.

Such features, of course, first need explaining. One general theory directs attention to employers' labour use strategies. By substituting part-time for full-time employees, it is argued, employers expand their options in the deployment of people to tasks and generally incur lower labour costs (Robinson, 1985). But why do women form such a large proportion of part-time workers? Beechey and Perkins offer the following suggestion:

the division of labour within the family and the gender ideology based upon this are also part of the explanation, for employers regard women as...ideal employees to work in... caring occupations (Beechey and Perkins, 1987).

The reason why women are seen as "ideal employees" might well draw on the cultural stereotype of women employees as passive and compliant. This notion has also found its way into the sociological literature with Goldthorpe's view that:

on account of their location within the wider social structure as well as the form of their employment such workers are unlikely to constitute a labour force in which any very strong interest in developing greater organizational power and curtailing managerial prerogatives either exists or can easily be developed (Goldthorpe, 1985, quoted in Beechey and Perkins, 1987).

Goldthorpe also asserts that part-time workers "stand outside and may not seek to become strenuously involved in "the web of rules" which...represent the characteristically modern way of regulating employment relationships". (Goldthorpe in Beechey and Perkins, 1987) If true, these arguments might help to account for the preponderance of women in part-time employment and would form the basis for predicting relatively quiescent and harmonious employment relations wherever these patterns of employment were to be found. At the moment, however, and in relation to general practice, we have no attitudinal data from either staff, managers, or doctors to substantiate or refute the claims. It would be unwise, therefore, to hypothesize the relationship between this feature of employment in general practice and the character of employment relations.

The structure of employment relations in general practice

Most commentators agree that organization structure should be regarded as an important factor influencing the form and character of employee relations

(Dastmalchian, Blyton and Adamson, 1991). A simple definition of organization structure is that it refers to "the way in which management organizes its own activities" (Marchington, 1982). In terms of employment relations, then, the major structural features of any organization would include: the distribution of authority to make decisions on staffing matters; the extent and formality of procedures for managing employee relations; and the allocation of staff management roles. These structural variables closely follow the dimensions identified in the Aston studies (Pugh and Hickson, 1976) and in this section we report the findings of our own survey of staff management arrangements in general practice. This survey was the first stage of a project which aims to define the nature and scope of human resource management in general practice. The second stage, which includes interviews with practice managers and clinicians, is designed to elaborate the findings from the questionnaire survey and will be reported separately.

Methods used in stage one of the study

A sample of 750 practices was randomly selected from the lists supplied by 23 FHSAs. A total of 2,966 practices were stratified into four size bands (the largest being practices with six or more partners). The final sample consisted of 86 practices in Band 1; 102 practices in Band 2; 388 practices in Band 3; and 174 practices in Band 4. For the purposes of analysis practices in Bands 1 and 2 were grouped together and classified as "small"; practices in Band 3 were classified as "medium"; and practices in Band 4 were classified as "large" practices.

A postal questionnaire was sent to the practice manager in each practice and consisted of three sections. Section 1 asked for details of the person completing the schedule. Section 2 contained questions about the practice and Section 3 sought details of how the practice dealt with a range of staffing matters (such as who had the authority to make decisions on a range of hypothetical issues); how precisely policies and procedures specified the way staffing issues were dealt with; and how much flexibility existed in who performed various tasks. Replies were received from 477 (64 per cent) practices.

Analysis of the replies consisted of using the data from Section 3 of the questionnaire to calculate delegation, formalization and specialization scores for each practice:

- *Delegation* was measured by the degree of delegation of authority in decision making, and ranged from "high" (where general practitioners delegated a large proportion of decisions to practice manager); through "medium" (where decisions were jointly taken by partners and the practice manager); to "low" (where decisions were made by partners alone). An overall delegation score was computed by summing scores for 12 hypothetical issues (for example: "who would normally have the authority to promote a receptionist to a senior receptionist post?")
- *Formalization* was measured by the extent to which formal rules, policies, or procedures specified the way in which 11 staffing matters (such as grievances, recruitment, promotion, etc.) were handled. On the

basis of overall scores on the 11 items practices were classified as "high", "medium" or "low" on this variable.

- *Specialization* was measured by how frequently staff roles were changed around. If, for example, the role of practice manager was "never" performed by another member of staff this indicated a "high" degree of specialization. A "low" degree of specialization indicated that staff in the practice frequently did each others' jobs.

Results

Table II shows how small, medium and large practices scored on three structural variables. For each of the variables there were statistically significant differences as practices increased in size. On the delegation variable, for example, small practices were more likely to have a low score while larger practices were characterized by higher degrees of delegation.

Structural variable	Size of practice					
	Small (<i>n</i> = 141)		Medium (<i>n</i> = 223)		Large (<i>n</i> = 110)	
Delegation						
Low	29	(21)	17	(8)	5	(4)
Medium	78	(55)	128	(57)	57	(52)
High	34	(24)	78	(35)	48	(44)
Formalization						
Low	34	(24)	40	(18)	14	(13)
Medium	77	(55)	128	(57)	63	(57)
High	30	(21)	55	(25)	33	(30)
Specialization						
Low	25	(18)	12	(5)	5	(4)
Medium	91	(64)	164	(74)	71	(65)
High	25	(18)	47	(21)	34	(31)

Table II.
Structural variables – by
size of practice (values
are numbers (%
of practices))

Table II.
Structural variables – by
size of practice (values
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These overall scores, however, mask some interesting differences when delegation is analysed by type of issue. Table III shows the number of practices reporting that the practice manager normally has the authority to make decisions for each of the 12 hypothetical issues. The areas where the majority of practice managers had independent authority to make decisions were: training for non-clinical staff, non-clinical staff grievances and appraisal and health and safety. This was the case in small, medium and large practices. Thus the authority of the practice manager is limited to the "soft" issues such as training and staff appraisal. Partners maintain considerable influence over the "hard" issues of discipline and dismissal in the majority of practices and virtually full control over matters such as their own working conditions (see, for example, the issue labelled "conditions" in Table III. The label refers to an item in the

questionnaire about extending surgery hours). This finding is similar to that of Atkinson and Meager from their survey of small businesses and their conclusion that "the managerial grip of the small firm owner/proprietor is a strong one" (Atkinson and Meager, 1994, p. 60). Our finding further suggests a distinct separation in general practice between the clinical domain, over which doctors have full control, and the non-clinical domain, over which practice managers have considerable, but not total control.

Issue	Percentage of practices where manager (alone) has authority to make decisions
Conditions	0.8
Equal opportunities	18.9
Health and safety	70.8
Recruitment	37.2
Clinical staff	
Appraisal	3.1
Discipline	14.0
Non-clerical staff	
Appraisal	56.0
Discipline	43.6
Dismissal	14.7
Grievance	64.8
Promotion	24.2
Training	55.7

Table III.
Practice manager's
authority to make
decisions on 12 staffing
matters

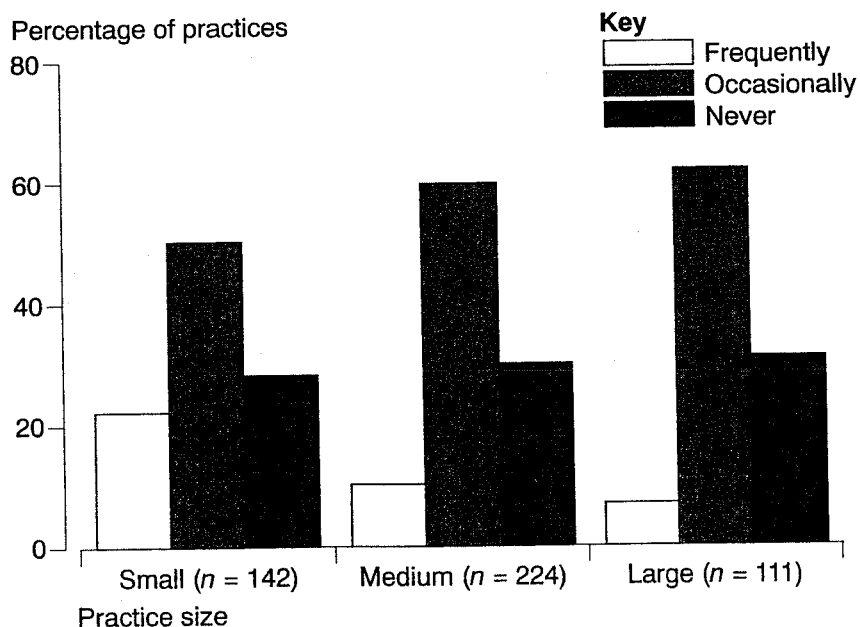
Table II also shows that size of practice is associated with degrees of formality. Small practices are less formal than large practices in their handling of staffing matters: 24 per cent of small practices had a "low" degree of formalization in contrast to 13 per cent of large practices. The proportion of practices with "high" levels of formality, however, are very similar for all sizes of practice. This probably reflects the very formal way in which all practices deal with particular matters. These are shown more clearly in Table IV. Maternity leave, grievances and discipline are the issues which are dealt with very formally (reflecting the legal requirements covering these areas). The least formally handled matters were trade union recognition (which was seen as "not applicable" by over half of the respondents), promotions and staff development. Reports that issues were dealt with in a formal way were supported by statements that written policies existed on these matters. Practices were less likely to have written policies on matters that were not dealt with formally. These levels of formality are considerably higher than the ones reported by Scott *et al.* in their survey (1989).

Table IV.
Practices (%) which
handle staffing in a
formal way

Staffing matter	Handled "very precisely" by rules and procedures (% of all practices (N = 477))
Grievances	68
Recruitment	39
Discipline	63
Redundancy	39
TU recognition	18
Staff development	18
Maternity leave	72
Promotions	18
Staff appraisal	27
Health and safety	64
Equal opportunities	45

Specialization has been defined as "the extent to which employees are employed to deal exclusively with various specialized activities in the organization" (Dastmalchian *et al.*, 1991, p. 79). This study measured specialization by the frequency with which certain roles in the practice were performed by someone else.

By way of illustration, Figure 1 shows the findings for the role of practice manager. Only 7 per cent of the larger practices said that this happened "frequently". Correspondingly, the larger practices were more likely to say that this "never" happened.

Figure 1.
Frequency of practice
managers' role being
performed by someone
else in the practices: by
size of practice

When the overall specialization scores are computed and tabulated by practice size the relationship is quite distinct (Table II). Small practices have a much lower degree of specialization and the proportion of practices with a high degree of specialization increases as the size of practice increases.

Size of service organizations and their employment relations

Size of practice, then, is a major factor associated with differences in the organization and management of staffing. The practice manager's authority to take independent action increases with practice size, as do the degrees of formalization and specialization in the practice. Such findings are consistent with those reported by organizational researchers over a long period of time (Kimberly, 1976; Scott, 1992). It is now well established that as organizations increase in size they can benefit from a more elaborate division of labour. This is reflected in the emergence of sub-divisions or departments and the resulting complexity is frequently seen to require greater managerial co-ordination. Because this is difficult to achieve through informal or personal methods in a large organization increasing size tends to produce more hierarchical levels and/or more impersonal (formalized) forms of control. In this way specialization, formalization and delegation are all associated with increasing size.

Size alone, however, does not determine the character of employment relations. As Curran (1990) and Rainnie (1991) have pointed out "size plays a role in the functioning of an organization only in relation to other factors". (Blyton and Turnbull, 1994, p. 236). Although, as we have seen earlier, some studies have enhanced our understanding by locating small manufacturing firms within their wider socio-economic environments (Rainnie, 1991) we think that such an approach is less useful in the case of general practice which is less dependent on the nature of its markets. So long as that is the case (and the long term implications of the NHS internal market must necessarily add caution to our previous statement) we feel that, along with Blyton and Turnbull (1994, p. 70) that "the principal actor in employment relations is...management". Size may influence the organizational structure of general practices in the way we have described, but the important task for investigation is the relationship between structure and process: or, more precisely, how those with authority shape employment relations through modes of control that are simultaneously attentive to the distinctive features of general practice workforces and their (managers') position as mediating "the sometimes diametrically opposed demands of external 'controllers' and internal 'carers'". (Ackroyd *et al.*, 1989, pp. 606-07)

It is in this latter respect that the service character of general practice requires emphasis. Schmenner (1986) has formulated a matrix designed to identify those features of service organizations which impact on managerial choice and strategies, including the management of staff. The matrix (see Figure 2) is based on two dimensions. First, the labour intensity of the service distinguishes between organizations which use small amounts of capital equipment but large numbers of staff (high labour intensity) and organizations

which are capital intensive but incur lower labour costs. Second, the degree of customer interaction coupled with the extent of customization of the service produces at one end organizations where the client has a large amount of participation in the delivery of the service and where the deliverers pay full attention to the individual needs of the client. These organizations are termed "professional services". At the other end of this dimension are organizations such as airlines where interaction with customers is brief and standardized and where there is little customization of the service. These organizations are termed "service factories".

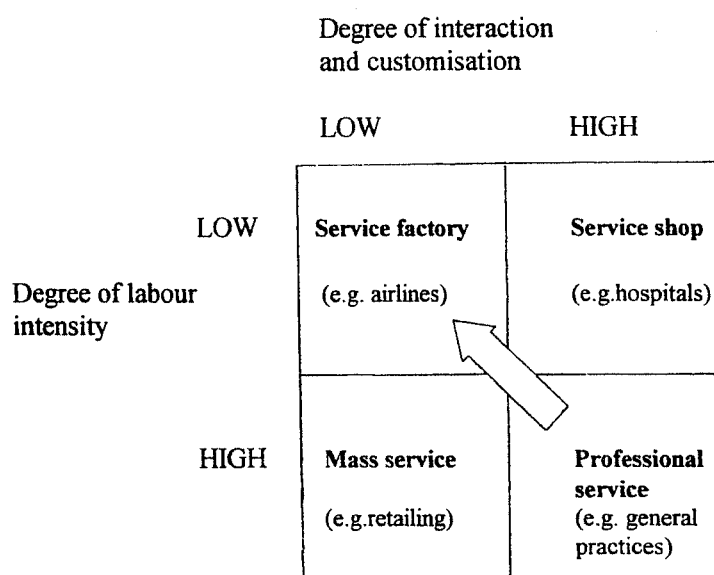


Figure 2.
The service process
matrix

Source : Schmenner, (1986)

According to Schmenner (1986) these axial differences generate different managerial problems in each quadrant. Thus, general practices, as professional services, have a high degree of contact with patients and the service process is made highly adaptable to their individual needs. The large proportion of professional staff, the variety of tasks and the current emphasis on quality implies that employees are given greater autonomy and their roles are less prescribed than in, say, a fast food restaurant. Such features may have important implications for strategies of organizational control which, as we have seen is effected through a complex web of high vertical and lateral trust relations. As Ackroyd *et al.* (1989, p. 610) have said: "the essential point is that these (public service) workers have considerable degrees of independence from direct control of their activities".

Such relations may not survive the changes which are currently being planned in primary health care. The long cherished independent contractor status of general practitioners looks set to be eroded by the changes announced

in the 1996 Queen's Speech. Any widespread take up of the opportunities enabled by these proposals would radically alter the partnership character of general practices and the distinctive authority relations which accompany it. A new breed of practice manager not steeped in the culture and traditions of general practice might serve to create a much more business like atmosphere quite appropriate for the time when:

- (1) practices could be directly employing the large numbers of currently attached staff whose terms and conditions would then most likely be settled outside nationally determined norms; and
- (2) clinicians are expected to be managerially accountable via budgets, guidelines and health promotion targets.

If only some of these possible changes happen it will give credence to Schmenner's view that "for many existing services the pressures for control and lower costs will tend to drive them toward the diagonal and/or up it" (Schmenner, 1986, p. 41).

Conclusion

Employment relations in general practice are influenced, as elsewhere, by a range of factors. In this paper we have concentrated on three factors: distinctive features of the employment relationship, size and the service location/character of general practice. We have been particularly concerned to identify the professionalized and gendered features of the employment relationship in general practice since this is increasingly regarded as central to any analysis of work organizations. Second, our data have shown that the size of general practices affects the structural arrangements they have developed to deal with staffing matters. We have not been able to show how these arrangements are used in the day to day workplace setting since this forms the second phase of our study, but we expect to find a close articulation between the changing nature of primary care services and managerial responses to those changes. A key element of the managerial response we suspect must be the need to balance the interests of established staff in primary care organizations with the demands of the health polity to contain costs and expenditure.

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Human resource management in general practice: survey of current practice

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SUMMARY

Background. The organization and management of general practice is changing as a result of government policies designed to expand primary health care services. One aspect of practice management which has been under-researched concerns staffing: the recruitment, retention, management and motivation of practice managers.

Aim. A study set out to find out who is routinely involved in making decisions about staffing matters in general practice, to establish the extent to which the human resource management function is formalized and specialized, and to describe the characteristics of the practice managers.

Method. A postal questionnaire was sent to a stratified random sample of 750 general practices in England and Wales in February 1994 enquiring about the practice (for example, the fundholding status and number of general practitioner partners), how the practice dealt with a range of staffing matters and about the practice manager (for example, employment background and training in human resource management). Practices were classed as small (single-handed and two or three general practitioner partners), medium (four or five partners) or large (six or more partners).

Results. Replies were received from 477 practices (64%). Practice managers had limited authority to make decisions alone in the majority of practices although there was a greater likelihood of them taking independent action as the size of practice increased. Formality in handling staffing matters (as measured by the existence and use of written policies and procedures) also increased with practice size. Larger practices were more likely than smaller practices to have additional tiers in their management structure through the creation of posts with the titles assistant practice manager, fund manager and senior receptionist. Most practice managers had been recruited from within general practice but larger practices were more likely than smaller practices to recruit from outwith general practice. Three quarters of practice managers reported having received some type of formal training in staff management.

Conclusion. This study shows that practice size is a major factor associated with differences in the organization and management of staffing. Any initiatives which increase the scale of primary care functions and services would have to address the issues of communication and coordination that might be associated with such a change.

Keywords: personnel management; practice management; practice staff; practice managers.

Introduction

THE reforms of the National Health Service in 1991 and subsequent government health policies have brought about a large number of changes in the organization and management of general practice. New funding arrangements and new functions and services, together with new supporting infrastructures, are transforming the simple family practitioner services into complex primary care organizations which are increasingly seen as, and see themselves as, small businesses.

Like other service-providing organizations, general practices are labour intensive and their outputs, as with any 'people' business,¹ depend on the recruitment, retention, management and motivation of staff at all levels. As Irvine has said:

'The quality of care is critically dependent on the attitudes, skills, and knowledge of each individual, working separately and together, and on the way these are combined in the organization as a whole.'²

Such coordination can only be achieved by some form of personnel management. Personnel management along with the character and style of industrial relations in general, has changed considerably over the last decade or so. One indication of change has been the emergence of new terminology: organizations are now more likely to refer to their human resource management function than to use the more familiar term personnel management. The precise meaning of the new term is a matter of debate among employment relations specialists^{3,4} but it is generally meant to signal a style of managing people which has a major concentration on individual employee development in addition to what are seen as the more administrative concerns of traditional personnel management. Some versions of human resource management include a more strategic focus for personnel policy by attempting to integrate this role more fully with the overall direction of the organization.⁵

Whatever human resource management actually is, the traditional personnel functions need to be performed in most organizations. Thus, it is still incumbent on all organizations to devise ways of recruiting, deploying, rewarding and developing staff. Although the policies and procedures used in commerce and industry are widely documented,⁶ little is known about human resource management in general practice. It might be assumed that many practices do not regard personnel matters as a distinct aspect of the general management function, but there is no clear evidence for this assumption. Furthermore, there may be important differences between large and small practices, and between fundholding and non-fundholding practices.

A three-year investigation (from 1993 to 1996) of human resource management in general practice was undertaken. This paper reports the findings of the first phase of this investigation, from October 1993 to October 1994. The aims of the first phase were: to find out who was routinely involved in making decisions about personnel matters; to establish the extent to which the human resource management function was formalized and specialized; and to describe the characteristics of the people involved in human resource management tasks.

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Method

A sample of 750 general practices was randomly selected from lists supplied by 23 family health services authorities in the following way. The sample was drawn in two stages: first, 33 family health services authorities were randomly selected from an alphabetical list of 98 authorities in England and Wales in 1993. Each of the selected authorities was asked to provide a list of general practices and 23 did so. Secondly, from these lists, 2966 practices were stratified into four size bands: single-handed practices, practices with two or three general practitioner partners, those with four or five partners (medium size practices), and those with six or more partners (large practices). As one focus of attention was on possible differences between fundholding and non-fundholding practices, a variable sampling fraction was used in each band ranging from one in nine in single-handed practices to one in two in medium and large practices. The final sample consisted of 86 single-handed practices and 102 practices with two or three partners (these were grouped together and classed as small practices), 388 medium practices and 174 large practices.

In February 1994 a postal questionnaire was sent to the practice manager in each practice. Reminders were sent to non-respondents after three weeks and again after a further three weeks. The questionnaire consisted of three sections.

One section contained questions about the practice: number and age of the general practitioner partners, its fundholding status, and number and employment status of other staff (clinical and non-clinical). Results are presented for practice size (number of partners) and fundholding status.

Another section sought details of how the practice dealt with a range of staffing matters:

- Who routinely had the authority to make decisions on 12 hypothetical issues (Appendix 1). The 12 issues were chosen by the three authors following discussions. A draft questionnaire was commented on by a small project advisory group consisting of a Royal College of General Practitioners administrator, a general practitioner researcher and an Advisory, Conciliation and Arbitration Service (ACAS) officer.
- Formality of procedures, that is, how precisely rules, policies and procedures specified the way in which 11

staffing issues were dealt with and whether written policies existed in the practice.

- Specialization of roles, that is, whether and how frequently the practice manager's role was performed by someone else in the practice and whether additional tiers existed in the management structure, for example with the creation of assistant practice manager, fund manager or senior receptionist posts.

The third section asked for information on the person completing the questionnaire, that is, the practice manager or person with similar job title: sex, age, hours of work, salary, employment background, length of time in post and training in human resource management.

Statistical analysis of the data was performed with the SPSS package. All statistics were derived from the chi square test at the 5% level of significance.

Results

Replies were received from 477 of the 750 practices (63.6%), from 142 small practices, 224 medium practices and 111 large practices according to the practice size classification using responses to the question on number of general practitioner partners. The response rate thus ranged from 57.7% in medium practices to 75.5% in small practices.

Of the 477 practices that responded, 188 (39.4%) were fundholding and 287 (60.2%) were non-fundholding; data missing for two respondents.

Authority to make decisions on human resource management

Table 1 shows which members of staff routinely had the authority to make decisions on 12 hypothetical staffing matters. Practice managers generally had the authority to make decisions alone in only five of the 12 areas (health and safety, and non-clinical staff appraisal, discipline, grievance, and training). Otherwise, the typical pattern for most human resource management issues was one of joint decision making between the practice partners and practice manager. As the size of practice increased there was a greater likelihood of practice managers taking independent action on all issues except health and safety,

Table 1. Practice managers' reports on which members of staff routinely had authority to make decisions about 12 hypothetical staffing issues.

Issue ^a	% of practices with authority for issue held by			
	GP partners only	Practice manager only	GP partners/ practice manager	Other staff member ^b
Conditions (<i>n</i> = 473)	69.3	0.8	28.3	1.5
Equal opportunities (<i>n</i> = 472)	28.2	18.9	51.7	1.3
Health and safety (<i>n</i> = 472)	6.4	70.8	17.2	5.7
Recruitment (<i>n</i> = 471)	13.0	37.2	42.5	7.4
Clinical staff				
Appraisal (<i>n</i> = 458)	60.9	3.1	15.9	20.1
Discipline (<i>n</i> = 472)	34.1	14.0	47.9	4.0
Non-clinical staff				
Appraisal (<i>n</i> = 470)	12.3	56.0	27.0	4.7
Discipline (<i>n</i> = 473)	13.1	43.6	38.9	4.4
Dismissal (<i>n</i> = 468)	31.6	14.7	51.9	1.7
Grievance (<i>n</i> = 471)	5.9	64.8	22.7	6.6
Promotion (<i>n</i> = 472)	18.0	24.2	54.4	3.4
Training (<i>n</i> = 472)	8.9	55.7	29.2	6.1

n = number of practices with practice manager respondent. ^aIssues described fully in Appendix 1. ^bCategories of personnel that had too few occurrences to mention individually.

and non-clinical staff appraisal. For example, on the issue of deciding to dismiss a secretary for stealing from a petty cash box (non-clinical staff dismissal), 7.1% of 141 practice managers in small practices, 14.9% of 222 in medium practices and 24.8% of 105 in large practices routinely had authority to act alone.

Approximately half of the practices (245, 51.4%) said that they had one general practitioner partner with a special responsibility for human resource management. However, this partner had a low involvement in decision making. Of the 245 practices with a partner designated in this way, the proportion of practices that were reported to leave the decision on each of the 12 staffing issues to this partner ranged from 1.6% (health and safety) to 18.8% (clinical staff appraisal) whereas the proportion that were reported not to include this partner in the decision at all ranged from 58.0% (clinical staff discipline) to 87.8% (conditions). Decisions were reported to be left to both the partner with special responsibility for human resource management and other staff in 4.1% to 37.1% of practices, on conditions and recruitment, respectively.

A total of 110 of the 188 fundholding practices (58.5%) and 134 of the 287 non-fundholding practices (46.7%) were reported to have a general practitioner partner with special responsibility for human resource management.

Formality of procedures

Respondents were asked to report how precisely (on a three-point scale: 'very precisely', 'to a moderate extent' and 'not at all', with the option to state 'not applicable') formal rules, policies and/or procedures specified the way in which staffing matters were handled. They were also asked to report whether written policies existed, as a possible confirmation of their assessment. Table 2 shows the proportion of practices reporting 11 staffing matters as being 'very precisely' dealt with by formal rules, policies and/or procedures.

In a high proportion of practices, maternity leave, grievance, health and safety, and discipline were reported to be dealt with very formally. For each of these four issues formality (as measured by the proportion of practice managers reporting 'very precisely') increased with the size of practice. Some issues, such as staff appraisal, staff development and promotion were generally reported to be dealt with less formally (as measured by the proportion of practice managers reporting 'to a moderate extent' or

'not at all') but there was a similar, although less pronounced, tendency for formality to increase with the size of practice.

A large proportion of practices reported that the issues of trade union recognition and redundancy were not applicable (54.5% and 32.5%, respectively). A higher proportion of small practices than large practices reported that the other nine issues were not applicable.

Reports that certain issues were dealt with in a formal way were backed up by statements that written policies existed on these matters. Smaller proportions of practices reported having written policies on matters that were not dealt with formally or were not applicable than on matters that were dealt with formally. For example, on the issue of trade union recognition fewer than 14% of practices were reported to have written policies whereas nearly 90% of practices were reported to have written policies on grievance and discipline.

Specialization of roles

Practice managers were asked whether and how frequently (frequently, occasionally or never) their job was performed by someone else in the practice, and whether there existed separate posts of assistant practice manager, fund manager and senior receptionist.

The practice manager role was reported to be performed by someone else: frequently, by 23.2% of small practices, 10.3% of medium practices and 7.2% of large practices; occasionally, by 50.0%, 59.8% and 63.1%, respectively; and never, by 26.8%, 29.9% and 29.7%, respectively.

Table 3 shows that a higher proportion of large practices than medium or small practices reported having created posts with the titles assistant practice manager and fund manager. In each of the three practice size groups, a large proportion of practices reported having a senior receptionist post; this proportion was highest (82.7%) in the large practices. A higher proportion of fundholding practices than non-fundholding practices were reported to have created these posts. For example, 53.7% of the 188 fundholding practices had created an assistant practice manager post compared with 34.1% of the 287 non-fundholding practices; $P < 0.001$.

Information on practice managers

A total of 409 of the 477 practice managers were women (85.7%) and 65 (13.6%) were men; data missing for three respondents. Approximately three quarters of the practice managers (77.3% of 475 respondents) were aged between 40 and 59 years.

About half of respondents (52.0% of 475) estimated that their hours of work were between 30 and 39 hours per week but over a third (35.1% of 475) reported working between 40 and 49 hours per week. Of 475 practice managers, 36.2% reported receiving an annual salary of between £10 000 and £15 999. There was a statistically significant difference between salaries in the small

Table 2. Staffing issues reported by practice managers to be dealt with 'very precisely' in formal rules, policies and/or procedures, by size of practice.

Staffing issue	% (no.) of practices in which issue dealt with very precisely			
	Small	Medium	Large	All
Maternity leave	64.7 (90)	73.5 (164)	83.3 (90)	73.2 (344)
Grievance	59.0 (82)	70.7 (157)	80.7 (88)	69.6 (327)
Health and safety	64.7 (90)	61.4 (137)	70.6 (77)	64.5 (304)
Discipline	52.9 (73)	66.7 (148)	74.3 (81)	64.4 (302)
Equal opportunities	44.6 (62)	44.6 (99)	50.0 (54)	45.8 (215)
Recruitment	39.7 (54)	37.7 (83)	46.7 (50)	40.4 (187)
Redundancy	34.1 (46)	45.0 (99)	38.0 (41)	40.2 (186)
Staff appraisal	21.7 (30)	26.0 (58)	33.9 (37)	26.6 (125)
Staff development	16.5 (23)	18.0 (40)	22.9 (25)	18.7 (88)
Promotion	19.6 (27)	15.2 (34)	22.9 (25)	18.3 (86)
Trade union recognition	10.9 (15)	15.4 (34)	15.9 (17)	14.2 (66)

Table 3. Practice manager reports of practices having created assistant practice manager, fund manager and senior receptionist posts, by size of practice.

Job title	% of practices with post created		
	Small (n = 141)	Medium (n = 223)	Large (n = 110)
Assistant practice manager	27.0	38.1	56.4
Fund manager	14.9	30.5	58.2
Senior receptionist	56.7	70.9	82.7

n = number of practices with practice manager respondent.

and large practices, with 25.4% of 142 and 2.7% of 111, respectively, reporting to receive an annual salary of less than £10 000 ($P<0.05$). Responses indicated that fundholding practices paid higher salaries to their practice managers: 9.0% of 188 fundholding practices paid annual salaries of £26 000 or more to their practice managers compared with 0.3% of 287 non-fundholding practices; $P<0.001$.

Most practice managers had been recruited from within general practice: 32.0% of 475 respondents reported having been promoted from the practice where they presently worked and 21.1% reported having been recruited from another general practice. Responses indicated that 14.9% of the 475 respondents had been previously employed outwith general practice in private sector management (the proportion rose to 20.2% of the 188 practice managers in fundholding practices) and 12.4% had been in a managerial post in the public sector. Large practices were significantly more likely than small or medium practices to recruit practice managers from outwith general practice: 38.7% of 111 managers in large practices reported having been recruited from public or private sector management posts compared with 28.6% of 224 and 16.2% of 142 in small and medium practices, respectively ($P<0.05$). The length of time that the practice managers had been in their present post was evenly spread: 10.3% of 477 respondents reporting this as being less than one year, 35.2% from three to five years and 15.3% over 11 years.

About three quarters of practice managers (76.8% of 474) said that they had received some type of formal training in human resource management. Diplomas and short courses accounted for the majority of training received. In the 245 practices that reported that one general practitioner partner had a special responsibility for human resource management, fewer than one fifth of these partners had formal training in human resource management. A significant difference was found between general practitioner partners with special responsibility for human resource management in fundholding practices compared with those in non-fundholding practices, with 20.0% of 110 partners and 13.4% of 134 partners, respectively, being reported as having received such training ($P<0.05$).

Discussion

The overall response rate of 64% was satisfactory for a postal questionnaire, although the low response rate from medium practices (58%) suggests some caution in interpreting the results from medium practices. More confidence can be attached to the results from small practices where the response rate was 76%.

Practice size (as measured by the number of general practitioner partners) is a major factor associated with differences in the organization and management of staffing matters. Responses in this study indicated that as the size of practices increased so did: the practice manager's authority to take independent action; the degree of formality in the handling of staffing issues; the specialization of the practice manager's role; and the likelihood that the practice manager had been recruited from outwith general practice. There appeared to be some confusion, however, about the distribution of authority for human resource management decisions in some practices, with general practitioner partners responsible for human resource management having low involvement in decision making. The discrepancies could have arisen from careless completion of the questionnaires or from genuine confusion about the distribution of authority for human resource management in the practices.

Related to practice size but perhaps exercising an independent influence on organization is fundholding status. The findings suggest that fundholding practices were more likely than non-

fundholding practices to have recruited people to 'middle management' positions, such as assistant practice manager, particularly from the private sector. In order to recruit such persons it might be necessary to offer salaries comparable to those in the private sector and this might account for the payment of higher salaries to managers in fundholding practices.

The findings in relation to size are consistent with those reported in other settings.⁷ It is now well established that as organizations increase in size so do the complexity and formality of their internal structures. Thus, as size increases so do the number of levels in the management hierarchy, the specification of procedures, and the specialization of functions.⁸ Other consequences which tend to flow from these changes are increasing problems of delegation, communication, and control within and between the different levels in the hierarchy. Essentially then, large organizations tend to be more bureaucratic than small organizations.

Bureaucracy is a term that is often used pejoratively, to refer to inefficiency, obstructiveness and rigidity. A more objective analysis might, however, see bureaucracy as a system of administration characterized by hierarchical division of labour, continuity (positions in the system are defined posts with a career structure), impersonality (work being conducted according to prescribed procedures without arbitrariness or favouritism), and expertise (office holders being selected according to merit and trained for their role).⁹ Looked at in this way, bureaucracy becomes less of a problem and more a rational way of organizing work activity.

This perspective is more likely to be of encouragement to those who see the NHS as being primary care led than to those who would wish to maintain the character of general practice as personal, small scale and informal. The latter group will have to consider their ability to maintain such a culture in an environment heavily influenced by government-initiated change away from personal, small-scale, informal practice. It is clear from experience with other initiatives such as fundholding and hospital trust status that such government-initiated change develops considerable momentum. In the case of fundholding, for example, the government has announced its intention to extend the options for general practices to participate in the scheme.¹⁰ If this anticipated expansion occurs, larger scale primary care organizations will be required to consider all areas of their working strategies, including with regard to their human resource management.

The term human resource management is used to refer to a style of management which flourished in the changed industrial relations climate of the 1980s where intense competition required organizations to pay close attention to customer needs and requirements via individualized contracts, flexible working and team building. As the results of the present study indicate that general practices do not yet regard 'personnel matters' as a distinct management function, it might be concluded that they are a long way from adopting such 'state-of-the-art' management styles. Even so, competitive pressures and the increasing amount of budget setting might encourage a new breed of practice manager in the larger practices to push for changes in staff management. Their ability to succeed in such initiatives would depend mainly on the nature of their relationship with the general practitioner partners in these practices. It is not easy to foster a sense of corporateness in organizations dominated by a professional 'core'.¹¹ This is not so much a case of managers and professionals being unable to 'get together' but of medical professionals being so preoccupied with their work tasks that they are unable to develop a sense of the practice as a whole requiring strategic direction.

Appendix 1. Twelve hypothetical staffing issues: practice managers were asked who in the practice routinely had authority to make decisions on each of the issues.

Conditions: make a final decision on extending surgery hours.

Equal opportunities: decide appropriate action when a candidate for a job alleges to have been the victim of sexual or racial discrimination.

Health and safety: decide to introduce new system for recording minor accidents in the practice.

Recruitment: make the final decision on the candidate selected for a receptionist post.

Clinical staff

Appraisal: make the final assessment of performance of a district nurse in an appraisal exercise.

Discipline: decide appropriate action when a practice nurse has allegedly been rude to a patient.

Non-clinical staff

Appraisal: make the final assessment of the performance of a member of non-clinical staff in an appraisal exercise.

Discipline: decide appropriate action when a non-clinical member of staff has allegedly been rude to a patient.

Dismissal: decide to dismiss a secretary for stealing from petty cash box.

Grievance: decide appropriate action when a grievance is raised by a cleaner.

Promotion: decide to promote a receptionist to senior receptionist post.

Training: decide to introduce a training course for practice staff.

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